

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01278 CERTIFICATE OF DEATH 01261

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 3 (Dagsboro Road)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ERNEST Middle LEE Last ADKINS		4. DATE OF DEATH Month JANUARY Day 24th Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH October 7, 1887
9. AGE (In years, last birth day) 74 yrs.		10. IF UNDER 1 YEAR: Months 3 Days 7 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Carpenter- House Construction		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Peter H. Adkins		14. MOTHER'S MAIDEN NAME Mary Holland	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Addie M. Adkins (Wife) Address R.D.# 3 Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Hemorrhage 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of lung (Bronchiogenic) DUE TO (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		INTERVAL BETWEEN ONSET AND DEATH 1 hour 6 mos ±	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work N/A	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 6/1 to death , 19 62 , that (I) (we) last saw the deceased alive on 1/20 19 62 and that death occurred at 5:00 M, from the causes and on the date stated above.			
22a. SIGNATURE Ernest W. Larmore		22b. DATE SIGNED Jan. 1/1962	
22c. PHYSICIAN'S NAME (Type) Dr. Ernest W. Larmore		22d. ADDRESS Delmar, XXXX Delaware	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 26, 1962	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR Jan 30 '62 25b. REGISTRAR'S SIGNATURE Arthur L. Haines	

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TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01279

01262

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> 23X-2			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>K.F.D.I. Bx. 40</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>				e. 15 RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>MAMIE</u> Middle <u>E.</u> Last <u>AMES</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>11</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 24, 1891</u>	
9. AGE (In years last birthday) <u>70</u> yrs.		IF UNDER YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>	
10b. KIND OF BUSINESS OR INDUSTRY <u>House Wife</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>George Garrison</u>			
14. MOTHER'S MAIDEN NAME <u>Lonnie Savage</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT <u>Lena Washington</u> Address <u>Pocomoke City, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO <u>Chronic Glomerulonephritis</u> Conditions, if any, which gave rise to immediate cause (b) <u>5-6 years</u> (c) <u>5-6 years</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u>Carcinoma of Thyroid & local metastasis.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>5-6 years</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u>19</u> e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5 Jan 1962</u> to <u>11 Jan 1962</u> , that (I) (we) last saw the deceased alive on <u>11 Jan 1962</u> , and that death occurred at <u>2:00 P.M.</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Joseph F. General</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type)	
22d. ADDRESS				22e. ADDRESS		22f. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-14-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Red Hill Cem.</u>		23d. LOCATION (City, town or county) (State) <u>Keller Va.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Samuel Savage</u>				25a. REC'D BY REGISTRAR <u>Jan 17 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	

013379

Dec 24, 1841 20

No - George Garrison
Donor's Home Wife Virginia
112A
New Washington Washington

General George Washington
1-14-42 Hill Hill
Keller
VA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician. Payment may be retained by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Item 20a Film 305
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01280
Items 8 & 9 Film 306 1/31/62 ink
01263

1. PLACE OF DEATH
a. COUNTY **Wicomico** **MARYLAND**
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **Salisbury** c. LENGTH OF STAY IN 1b **13 days**
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) **Deer's Head State Hospital**

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE **Maryland** b. COUNTY **Wicomico**
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) **White Haven**
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Middle Last
Woodland A. Anderson

4. DATE OF DEATH Month Day Year
January 16 19 62

5. SEX **Male** 6. COLOR OR RACE **White** 7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH **3/28/1878** AGE (In years last birthday) **83 yrs.** IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) **Merchant** 10b. KIND OF BUSINESS OR INDUSTRY **Gen. Merchandise Maryland** 11. BIRTHPLACE (County & State, or foreign country) **U. S.** 12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME **William J. Anderson** 14. MOTHER'S MAIDEN NAME **Sarah L. Anderson**

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) **No** (If yes give war or dates of service) 16. SOCIAL SECURITY NO. 17. INFORMANT **Mrs. Elsie Anderson, White Haven, Md.** Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **Bronchopneumonia**
491X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) **Fracture of the right femur**
DUE TO
(c)
INTERVAL BETWEEN ONSET AND DEATH
4 days
2 months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☒ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour e.m. p.m. **19** 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from **Jan. 3 1962** to **Jan. 16 1962**, that (I) (we) last saw the deceased alive on **Jan. 16 1962**, and that death occurred at **8:55 A.M.** from the causes and on the date stated above.

22a. SIGNATURE **L. V. Maldve, M. D.** M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒ 22b. DATE SIGNED **1/16/62**

22c. PHYSICIAN'S NAME (Type) **L. V. Maldve, M. D.** 22d. ADDRESS **Deer's Head Hospital; Salisbury, Md.**

23a. BURIAL, CREMATION, REMOVAL (Specify) **Burial** 23b. DATE THEREOF **1/18/62** 23c. NAME OF CEMETERY OR CREMATORY **St. Mary's Cem., York, Md.** 23d. LOCATION (City, town or county) (State) **York, Md.**

24. FUNERAL DIRECTOR'S SIGNATURE **C. H. Brown, Brucy, Md.** ADDRESS **Brucy, Md.** 25a. REC'D BY REGISTRAR DATE **JAN 18 '62** 25b. REGISTRAR'S SIGNATURE **Arthur S. Kline**

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01281 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01264

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 12		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		d. STREET ADDRESS 711 E. Isabella St	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) D.O.A. - Pen Gen Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) STANLEY JOHN BARABAS				4. DATE OF DEATH Month JANUARY Day 12 Year 1962			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Jan. 25, 1907		9. AGE (In years last birthday) 54 yrs.	IF UNDER 1 YEAR Months 11 Days 17 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-J.I. Wells Co. (Sawman)		10b. KIND OF BUSINESS OR INDUSTRY Pa.		11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Barabas				14. MOTHER'S MAIDEN NAME Sophia Opusinski			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES II		16. SOCIAL SECURITY NO. II		17. INFORMANT Mrs. Mary Stanitski (Sister) 213 West 22nd Street Chester, Pa. (TR-4-1259)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) Jan. 15 / 1962							
ACTUAL SIGNATURE Dr. Earl L. Royer		EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md		DATE SIGNED Jan. 15 / 1962			
22b. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 16, 1962		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or country) (State) Salisbury, Maryland			
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND				24a. REC'D BY REGISTRAR JAN 18 '62 24b. REGISTRAR'S SIGNATURE Arthur L. House			

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James C. [unclear]

[Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01282
CERTIFICATE OF DEATH

01265

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Talbot	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 8 Mos. 6 Days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) St. Michaels	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Deer's Head State Hospital		d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Andrew Barnett		4. DATE OF DEATH January 13 19 62		5. SEX Male	
6. COLOR OR RACE Negro		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 6-12-05	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY Domestic		9. AGE (In years last birthday) 56 yrs.	
11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Andrew Barnett	
14. MOTHER'S MAIDEN NAME Bertha Johnson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 218-10-9865	
17. INFORMANT Hospital Records -- Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 331X Recurrent Cerebral Thrombosis w/quadruplegia DUE TO (b) Arteriosclerosis, General DUE TO (c) ? PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Arteriosclerotic Cardiovascular Disease		INTERVAL BETWEEN ONSET AND DEATH 5 Months ?	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from 5/8/61, 19 to 1/13/62, 19, that (I) (we) last saw the deceased alive on 1/13/62, 19, and that death occurred at 12:00 M. from the causes and on the date stated above.					
22a. SIGNATURE V. Juerman		22b. DATE SIGNED 1/13/62		22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.	
22d. ADDRESS Deer's Head State Hospital - Salisbury		22e. REC'D BY REGISTRAR DATE JAN 16 '62		22f. REGISTRAR'S SIGNATURE Arthur S. Kline	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-17-62		23c. NAME OF CEMETERY OR CREMATORY St. Michaels Cem.	
23d. LOCATION (City, town or county) St. Michaels Md.		23e. (State) Md.		23f. (Country)	

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

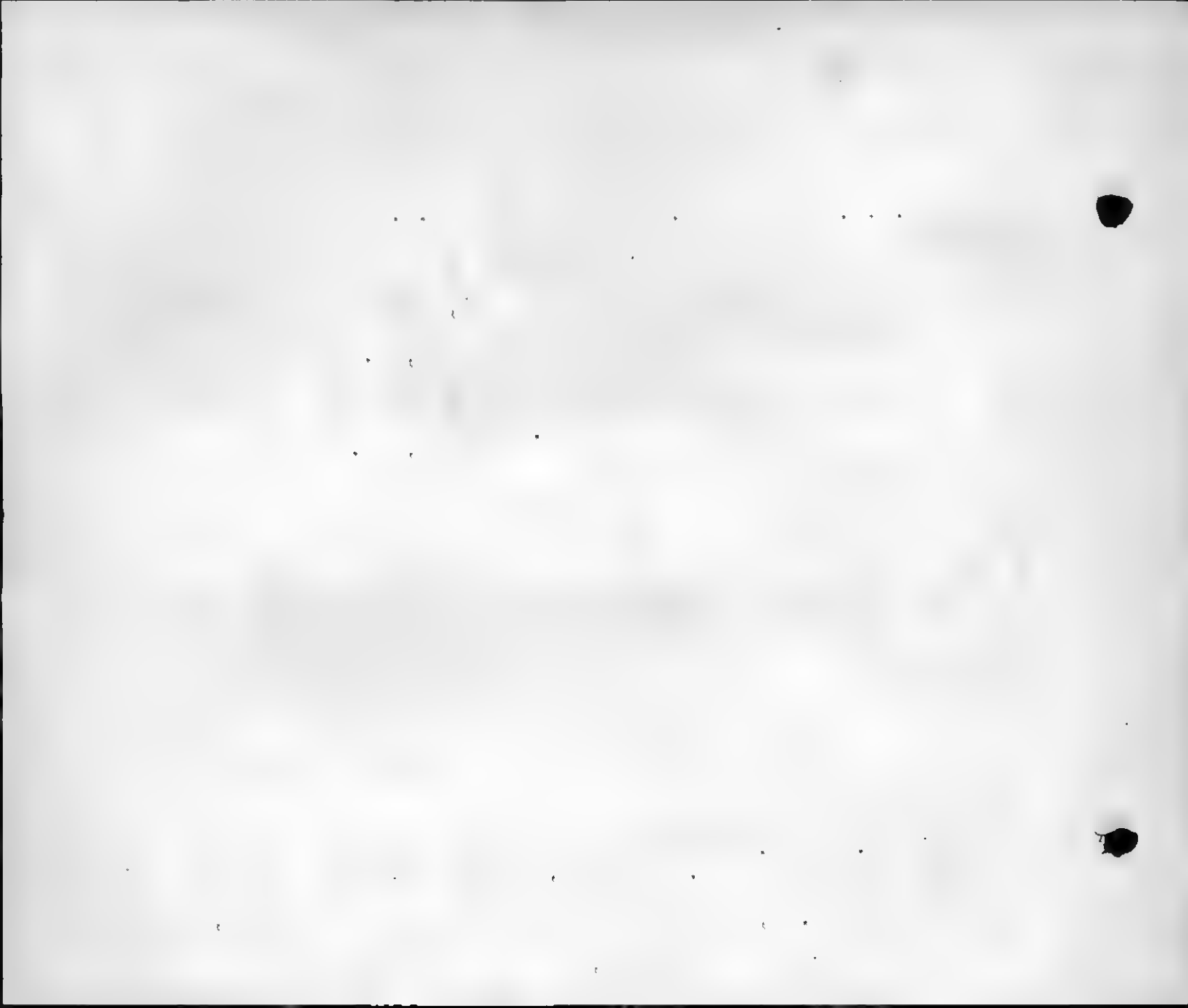
VS. A15ME
5M 2/57

Items 18 & 21 Filed 2-5-62 ams MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01283 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01266

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. LENGTH OF STAY IN 1b <u>X</u> <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. at Pen Gen. Hospital</u>			d. STREET ADDRESS <u>R.D.# 3 Delmar Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>VERONICA</u> Last <u>BAYLY</u>			4. DATE OF DEATH Month <u>JANUARY</u> Day <u>23</u> Year <u>1962</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 12, 1909</u>	9. AGE (In years last birthday) <u>52</u> yrs	IF UNDER 1 YEAR Months <u>8</u> Days <u></u> Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Ashley, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		13. FATHER'S NAME <u>Bernard Kazakavage</u>			
14. MOTHER'S MAIDEN NAME <u>Frances Berryusavage</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Mr. Martin Kassey (Brother) #69 Fall St Ashley, Pa.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute alcoholism</u> <u>322.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Chronic Alcoholism</u> (c) <u></u> DUE TO (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>					INTERVAL BETWEEN ONSET AND DEATH hours <u></u> years <u></u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u></u> a. m. <u>19</u> p. m. <u></u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>January 25, 1962</u>	
EXAMINER'S NAME (Type) <u>407 Camden Ave. Salisbury, Md</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 25, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>HOJLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY, MARYLAND</u>		24a. REC'D BY REGISTRAR <u>DATE 30 '62</u>	24b. REGISTRAR'S SIGNATURE <u>John S. Thomas</u>



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any of the information is necessary, please explain the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/6D

1
MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01284 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

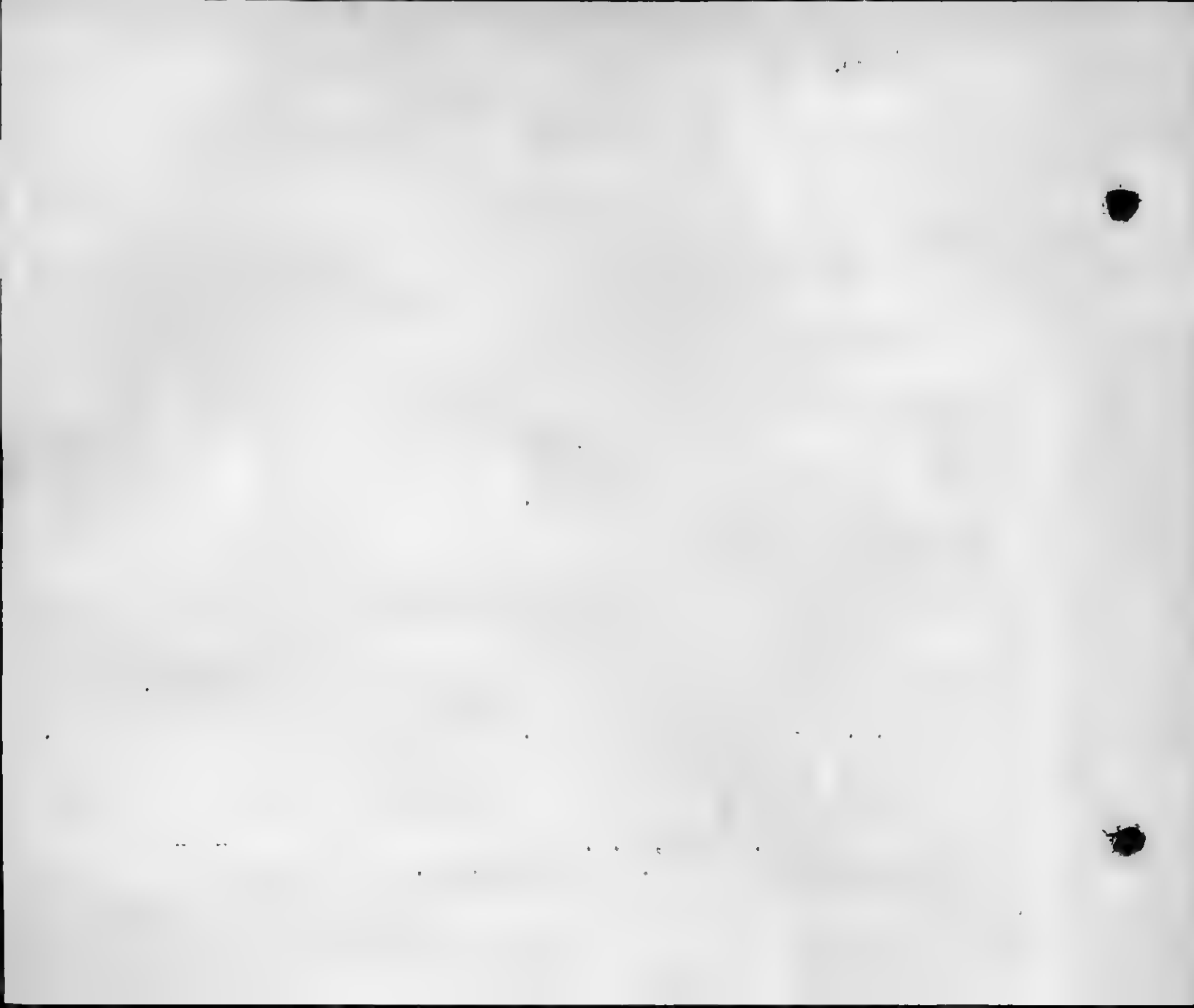
01284

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital		2. USUAL RESIDENCE (Where deceased lived, If Institution: Res. since before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Showell d. STREET ADDRESS 23X-2	
3. NAME OF DECEASED (Type or print) Clifford Calvin Bell		4. DATE OF DEATH 1-6-62	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 1, 1902
9. AGE (In years last birthday) 60 yrs.		10. IF UNDER 1 YEAR Months Days	
11. BIRTHPLACE (State or foreign country) Accomac Co., Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Alonzo R. Bell		14. MOTHER'S MAIDEN NAME Mag. Kellam	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 227-05-0904	
17. INFORMANT Elizabeth Bell		Address Showell, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushed chest. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last, (c) _____ DUE TO (d) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Driving car that ran off road and overturned. 20c. TIME OF INJURY Month, Day, Year Hour a.m. 10:30 p.m. 1-6-62 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) U.S. # 50 20f. (City or town) Willards (County) Wicomico (State) Md. 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 1-10-62 ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D. 407 Camden Ave. Salisbury, Md. 22a. BURIAL, CREMATION, REMOVAL (Specify) 22b. DATE THEREOF 1-9-62 22c. NAME OF CEMETERY OR CREMATORY Fairview Lawn Cem. Onancock Va. 22d. LOCATION (City, town, or country) (State) 23. FUNERAL DIRECTOR Henry H. Watson Pocomoke City, Md. 24a. REC'D BY REGISTRAR JAN 12 '62 24b. REGISTRAR'S SIGNATURE C. L. Kline			

MEDICAL CERTIFICATION

INTERVAL BETWEEN ONSET AND DEATH
Sudden

19. WAS AUTOPSY PERFORMED?
YES ☒ NO ☐



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01285

01268

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>✓</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>	
c. LENGTH OF STAY in 1b <u>83 days</u>		d. STREET ADDRESS <u>31st and St. Paul Streets</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Sara</u> <u>Howard</u> <u>Bier</u>		4. DATE OF DEATH Month Day Year <u>Jan.</u> <u>29</u> <u>19 62</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 2, 1875</u>
9. AGE (In years last birthday) <u>86 yrs.</u>		10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>John William Rombach</u>		14. MOTHER'S MAIDEN NAME <u>Clara Faux</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Mr. John S. Rombach-Stevensville, Maryland</u>	
17. INFORMANT <u>Mr. John S. Rombach-Stevensville, Maryland</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> DUE TO (b) <u>Malignant tumor of right femoral bone (type to be determined) with metastasis</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Nov. 7, 1961</u> , to <u>Jan. 29, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 29, 1962</u> , and that death occurred at <u>3:15 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. V. Maldve, M. D.</u>		22b. DATE SIGNED <u>1/30/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M. D.</u>		22d. ADDRESS <u>Deer's Head Hospital; Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2-1-62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Watsonstown Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Watsonstown, Pa.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>Wm J. Johnson</u>		25. REC'D BY REGISTRAR <u>31 '62</u>	
ADDRESS <u>Baltimore 13, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Wm J. Johnson</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

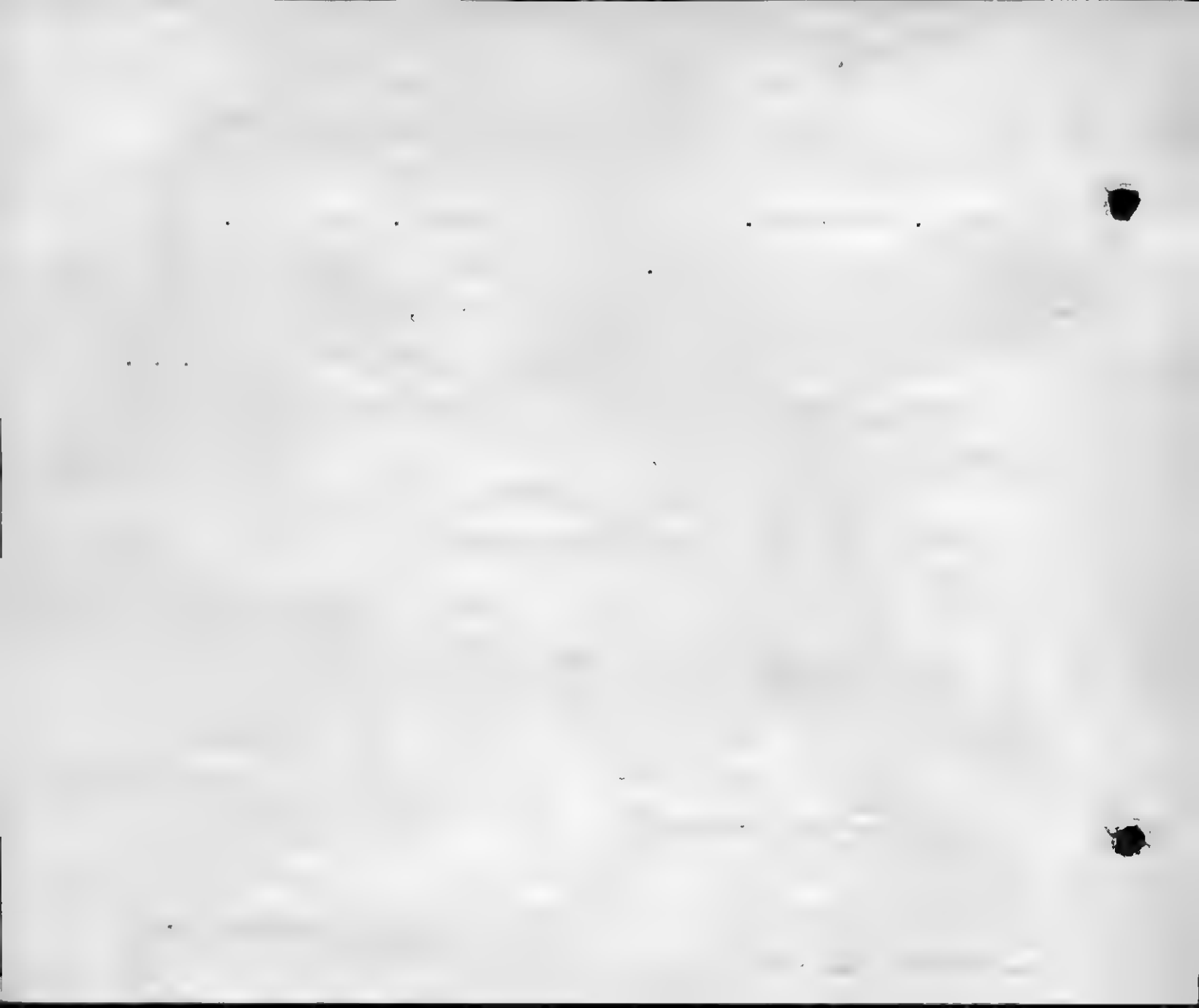
01286

CERTIFICATE OF DEATH

Items 5 & 6 Film G305 1/22/62 ink

01286

1. PLACE OF DEATH a. COUNTY Wicomico		2. USUAL RESIDENCE (Where deceased lived, if institutions; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1009 N. Division St.		d. STREET ADDRESS 1009 N. Division St.	
3. NAME OF DECEASED (Type or print) Mary C. Birkhead		4. DATE OF DEATH Month January Day 15 Year 1962	
5. SEX Female	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/>	9. AGE (In years last birthday) 98 yrs. Months 15 Days 182
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife		10b. KIND OF BUSINESS OR INDUSTRY Maryland	
11. BIRTHPLACE (County & State, or foreign country) U.S.A.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Elisha Dixon		14. MOTHER'S MAIDEN NAME Ann Parker	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. John Birkhead 1009 N. Division St.	
17. INFORMANT John Birkhead 1009 N. Division St.		Address 1009 N. Division St.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4 Gangrene right leg DUE TO (b) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour 19 Month, Day, Year a.m. p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from....., 1950 to.....1-11....., 1962. That (I) (we) last saw the deceased alive on.....1-14.....1962, and that death occurred at.....M, from the causes and on the date stated above.			
22a. SIGNATURE Frederic J. [Signature]		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) Frederic J. [Signature]		22d. ADDRESS M.D.	
23a. BURIAL, CREMATION, REMOVAL (Specify) burial	23b. DATE THEREOF 1/19/1962	23c. NAME OF CEMETERY OR CREMATORY Green acres	23d. LOCATION (City, town or county) (State) Salisbury Md.
24. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart		25a. REC'D BY REGISTRAR JAN 22 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. [Signature]			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01287

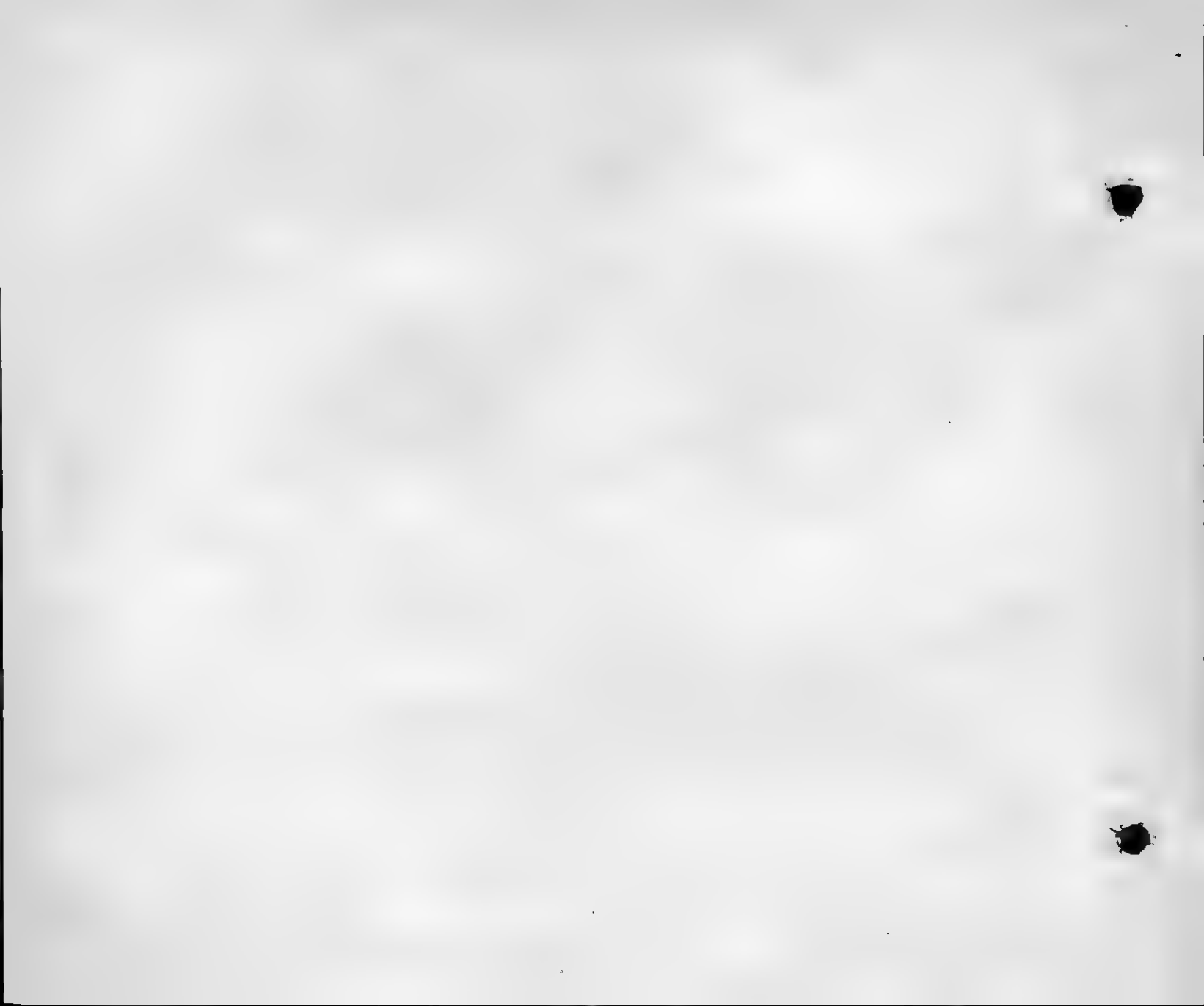
CERTIFICATE OF DEATH

01270

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> c. LENGTH OF STAY IN 1b <u>17 Weeks</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Snow Hill</u> d. STREET ADDRESS <u>RFD #1 Box 147</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Cordelia</u> First Middle Last 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 29 - 1904</u> 9. AGE (In years last birthday) <u>57 7/8</u> IF UNDER 1 YEAR: Months <u>7</u> Days <u>22</u> Hours <u>19</u> Min. <u>62</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Brother's</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Snow Hill, MD</u> 12. CITIZEN OF WHAT COUNTRY?		13. FATHER'S NAME <u>Ballit Laws</u> 14. MOTHER'S MAIDEN NAME <u>Mary Sturgis</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>None</u> 17. INFORMANT <u>Melvin Sturgis Blake</u> Address <u>Snow Hill, MD</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Respiratory Failure</u> } (c) <u>Metastatic Carcinoma of breast</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital), attended the deceased from <u>1/16</u> , 19 <u>62</u> to <u>1/22</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/22</u> , 19 <u>62</u> , and that death occurred at <u>7:15</u> M., from the causes and on the date stated above.							
22a. SIGNATURE <u>David Rafat MD</u> M.D. 22c. PHYSICIAN'S NAME (Type) <u>DAVID RAFAT MD</u>				22b. DATE SIGNED 22d. ADDRESS <u>Snow Hill MD</u>			
23a. BURIAL, CREMATION, OR DISPOSAL (Specify) <u>Burial Jan 27/62</u>		23b. NAME OF CEMETERY OR CREMATORY <u>W. Wesley</u>		23c. LOCATION (City, town or county) (State) <u>Snow Hill MD</u>			
24. REGISTERING OFFICER'S SIGNATURE <u>Wayne Dennis</u>		25a. REC'D BY REGISTRAR <u>JAN 24 '62</u>		25b. REGISTRAR'S SIGNATURE <u>William S. Thoms</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01288

01971

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN <u>MD</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Mardella Springs Run</u> d. STREET ADDRESS _____			
3. NAME OF DECEASED (Type or print) <u>Marada Elizabeth Brown</u> First Middle Last				4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>NEGRO</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>1893</u>		9. AGE (In years last birthday) <u>68</u> yrs.		10. IF UNDER 1 YEAR Months _____ Days _____			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTHPLACE (County, State, or foreign country) <u>Shoptown</u>			
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>Ges Hopkins</u>		14. MOTHER'S MARDEN NAME <u>Ardella Ennis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>?</u>		16. SOCIAL SECURITY NO. <u>?</u>		17. INFORMANT <u>Brook Gaslee</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute gastric hemorrhage</u> Conditions, if any, which gave rise to immediate cause (b) <u>Carcinoma of stomach</u> (a), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) _____ OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) _____							
20c. TIME OF INJURY Month, Day, Year _____ Hour a.m. _____ p.m. _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____			
20f. (City or town) _____		20g. (County) _____		20h. (State) _____			
21. I certify that (I) (this hospital) attended the deceased from <u>1-11-62</u> to <u>1-13-62</u> that (I) (we) last saw the deceased alive on <u>1-12-62</u> and that death occurred at <u>12:30 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>H. H. Brielle</u>				22b. DATE <u>1-13-62</u>			
22c. PHYSICIAN'S NAME (Type) <u>H. H. Brielle</u>				22d. ADDRESS <u>Medical Center Salisbury Md</u>			
23a. BURIAL, CREMATION, REMOVAL. (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-17-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Shoptown Cem</u>			
23d. LOCATION (City, town or county) <u>Shoptown Md</u>		23e. (State) <u>MD</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Brook M. Ward</u>			
24a. REC'D BY REGISTRAR <u>17 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, and by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

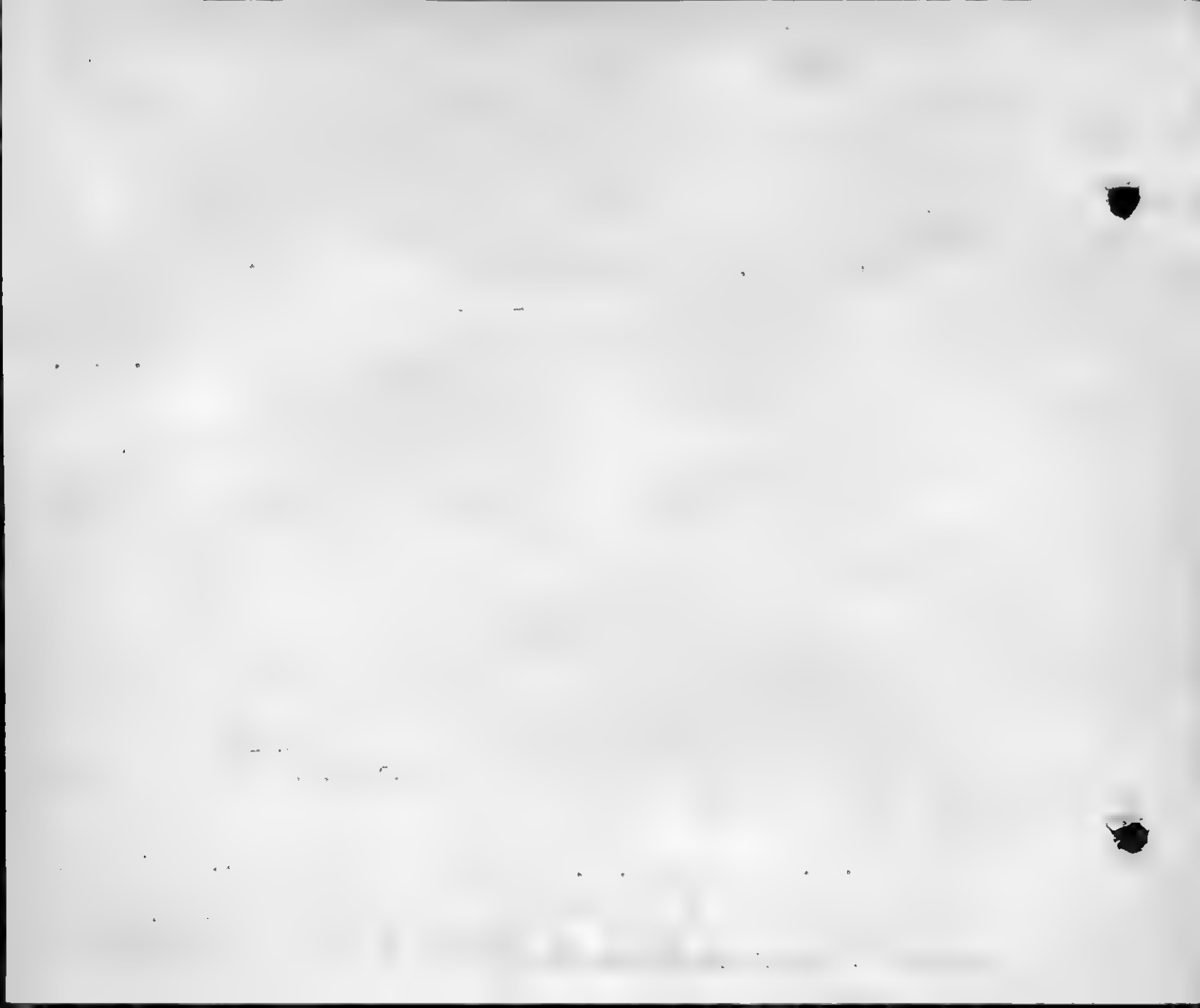
CERTIFICATE OF DEATH

01289

1972

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 3 Years d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Springhill Sanitarium		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE Delaware f. COUNTY Suxsex g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Selbyville h. STREET ADDRESS RFD i. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Cora M. BUNTING 4. DATE OF DEATH Jan. 6 19 62 5. SEX Female 6. COLOR OR RACE White 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH 7-3-1874 9. AGE (In years last birthday) 87 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife 10b. KIND OF BUSINESS OR INDUSTRY Own Home 11. BIRTHPLACE (County & State, or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME William Collins 14. MOTHER'S MAIDEN NAME Kathryn Hudson		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) XX (If yes give year or dates of service) XX 16. SOCIAL SECURITY NO. XXXX 17. INFORMANT Raymond Bunting Selbyville, Del. Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis (b) 3-2-X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year 19 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from 3/60 , 19... to 1-6-62 , 19... that (I) (we) last saw the deceased alive on 1/6/62 , and that death occurred at 1:35 P.M. from causes and on the date stated above. 22a. SIGNATURE E. M. Beardsley 22b. PHYSICIAN'S NAME (Type) E. M. Beardsley M. D. 22c. ADDRESS 207 Maryland Ave., Salisbury, Md. 22d. DATE JAN 17 '62			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1/9/62 23c. NAME OF CEMETERY OR CREMATORY Odd Fellows 23d. LOCATION (City, town or county) (State) Bishopville, Md.			
24. FUNERAL DIRECTOR'S SIGNATURE Edith Whaley Selbyville, Del. 25. REC'D BY REGISTRAR Arthur S. Frame 25b. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

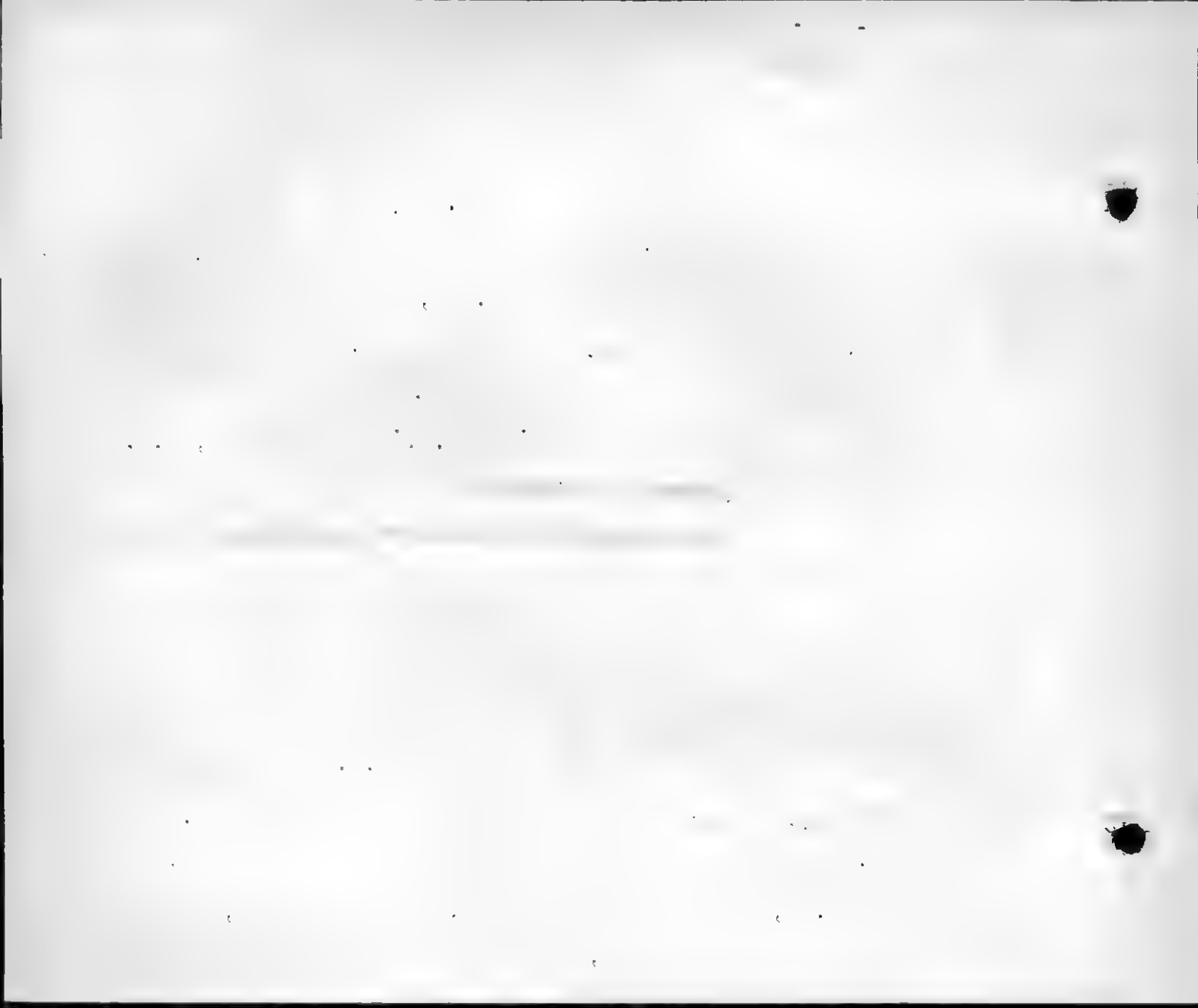
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01290

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01273

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution. Residence before admission) o. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS 618 S. Division St	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3 NAME OF DECEASED (Type or print) First LEMUEL Middle MALONE Last CANNON		4. DATE OF DEATH Month JANUARY Day 16 Year 19 62	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH Sept. 11, 1871
9. AGE (In years lost birthday) yrs. 90		IF UNDER 1 YEAR Months 4 Days 5 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired "Rigger"		10b. KIND OF BUSINESS OR INDUSTRY Construction	
11. BIRTHPLACE (State or foreign country) Wicomico Co. Maryland		12 CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William Cannon		14. MOTHER'S MAIDEN NAME Mary E. Gaskill	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Edward C. Adkins (Daughter)		Address 2405 Farley Place S.E. - Washington 21, D.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Biliary Cirrhosis - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ADENOCARCINOMA - COMMON BILE DUCT DUE TO (c) 			INTERVAL BETWEEN ONSET AND DEATH 3 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 			19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 2:45 P.M. , 19 62 , that (I) (we) last saw the deceased alive on 19 , and that death occurred at 2:45 P.M. , from the causes and on the date stated above			
22a. SIGNATURE H. Gray Reeves M.D.		22b. DATE SIGNED Jan. 18 / 1962	
22c. PHYSICIAN'S NAME (Type) Dr. Gray Reeves		22d. ADDRESS Medical Center Salisbury, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 19, 1962	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City, town, or county) (State) Salisbury, Maryland
24 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR JAN 22 '62		25b. REGISTRAR'S SIGNATURE Arthur E. Hines	

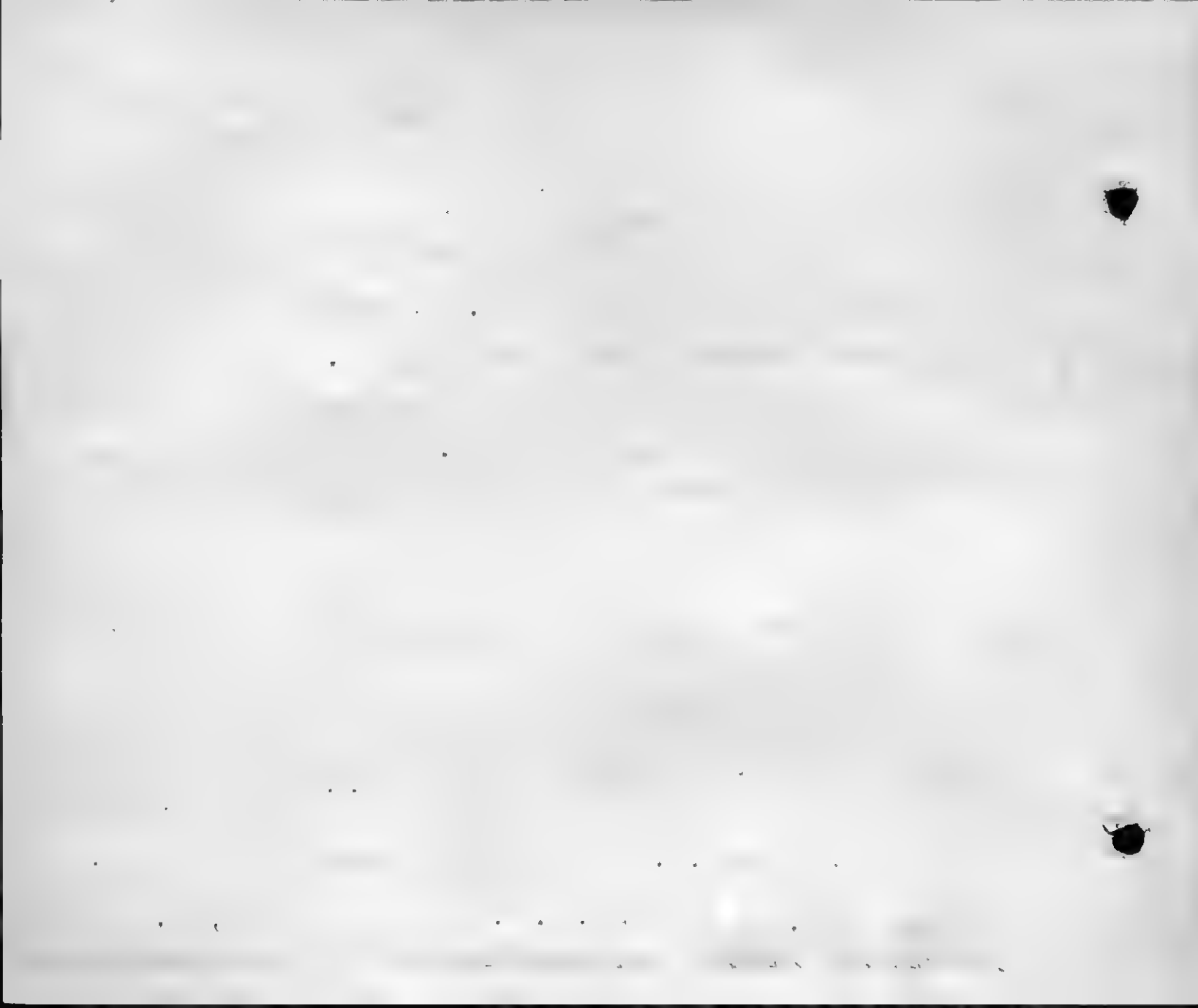


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01291 Items 7 & 9 Film G5C5 1/22/62 iwk 01271											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY		Wicomico		MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE		Maryland		b. COUNTY Caroline	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Salisbury		c. LENGTH OF STAY IN lb		138 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Preston	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		Deer's Head State Hospital		d. STREET ADDRESS		Rt. # 2		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First		Middle		Last		4. DATE OF DEATH		Month Day Year	
		Winfield		Dewey		Chambers		January		16 19 62	
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NE ER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)		IF UNDER 1 YEAR Months Days Hours Min.	
Male		White		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		Mar. 17, 1898		63/64			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?					
Bascomb Chambers Lumber				Caroline Md.		US					
13. FATHER'S NAME		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no		no		213-16-8296		Mrs. Audrey Lee Webster					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		19. INTERVAL BETWEEN ONSET AND DEATH									
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		1 1/2 years		Carcinoma of left lung							
DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)									
DUE TO		(c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
Nephrosclerosis, arteriolar											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)									
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
19											
21. I certify that (I) (this hospital) attended the deceased from August 31, 1961 to January 16, 1962, that (I) (we) last saw the deceased alive on Jan. 15, 1962, and that death occurred at 4:55 A.M. from the causes and on the date stated above.		22a. SIGNATURE		V. Juerman		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		1/16/62		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		V. Juerman, M. D.		22d. ADDRESS		Deer's Head Hospital; Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county)		(State)			
Burial		Jan. 19		Jr. O. U. A. M		Preston, Md.					
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		DATE		JAN 19 '62		Arthur S. Kneale	
Harry M. Hollis		PRESTON, MD.									



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

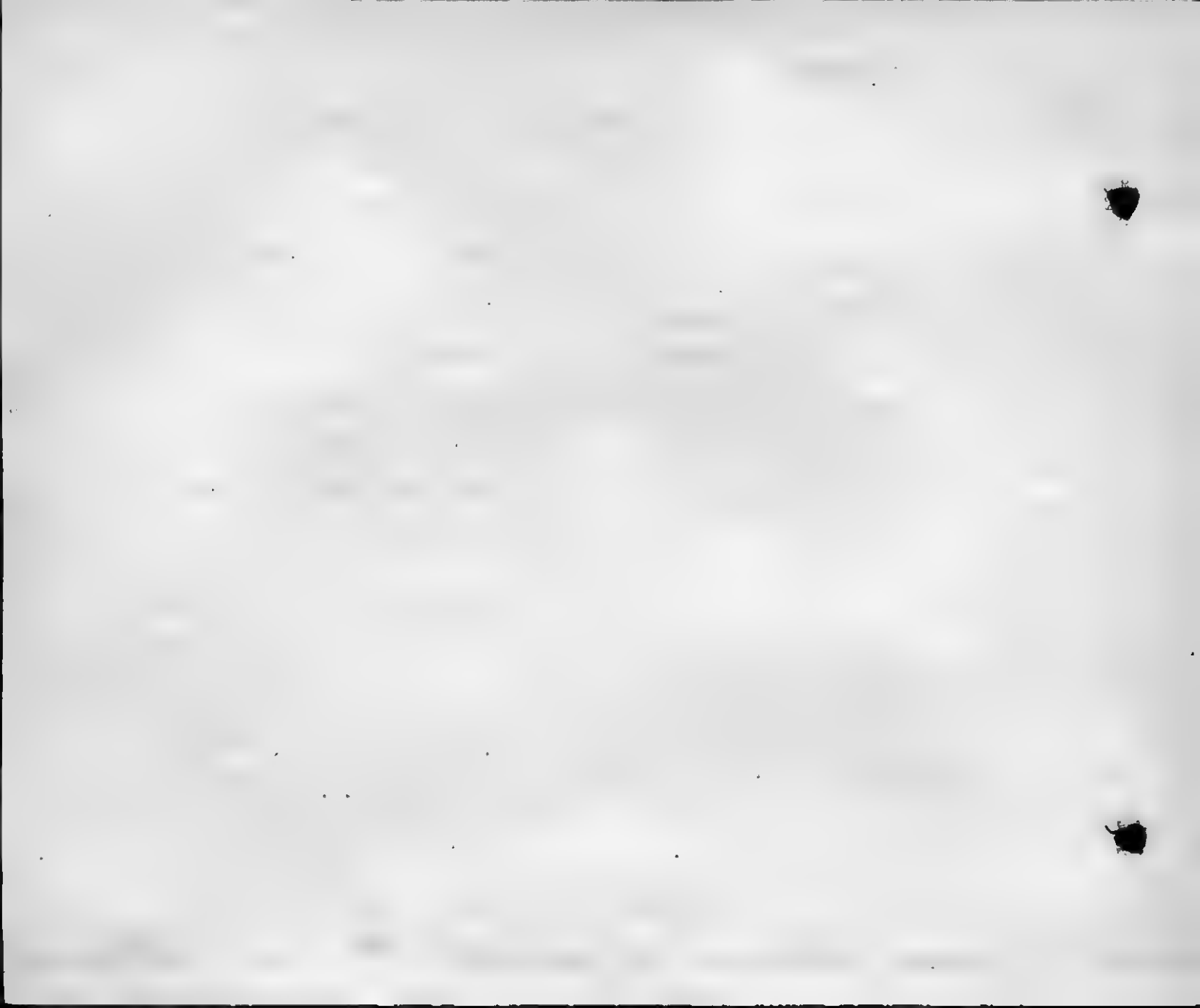
CERTIFICATE OF DEATH

01292

01275

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>365 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) e. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>623 Lake Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Roy</u> Middle <u>James</u> Last <u>Corbin</u>		4. DATE OF DEATH Month <u>January</u> Day <u>10</u> Year <u>19 62</u>		5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> <u>1886</u>		9. AGE (In years last birthday) <u>75</u> yrs. IF UNDER 1 YEAR: Months <u>7</u> Days <u>15</u> IF UNDER 24 HRS.: Hours <u>1</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Motor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>		11. BIRTH PLACE (Country & State, or foreign country) <u>Worcester Co</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
13. FATHER'S NAME <u>George Corbin</u>				14. MOTHER'S MAIDEN NAME <u>Mary Callens</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> 16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Clara Corbin</u> Address <u></u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>RECURRENT CEREBRAL THROMBOSIS</u> DUE TO (b) <u>Arteriosclerosis general</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u></u>										INTERVAL BETWEEN ONSET AND DEATH <u>5 min.</u> <u>?</u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Jan. 10, 19.61</u> to <u>Jan. 10, 19.62</u> , that (I) (we) last saw the deceased alive on <u>Jan. 10, 19.62</u> , and that death occurred at <u>M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>V. Juerman</u>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <u>1/10/62</u>		22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>		22d. ADDRESS <u>Deer's Head State Hospital; Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-15-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Cem</u>		23d. LOCATION (City, town or county) <u>Salisbury Md.</u>		(State) <u>M</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Booker W. West</u>				ADDRESS <u>130 Second St City</u>		25a. REC'D BY REGISTRAR <u>17 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Clara S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

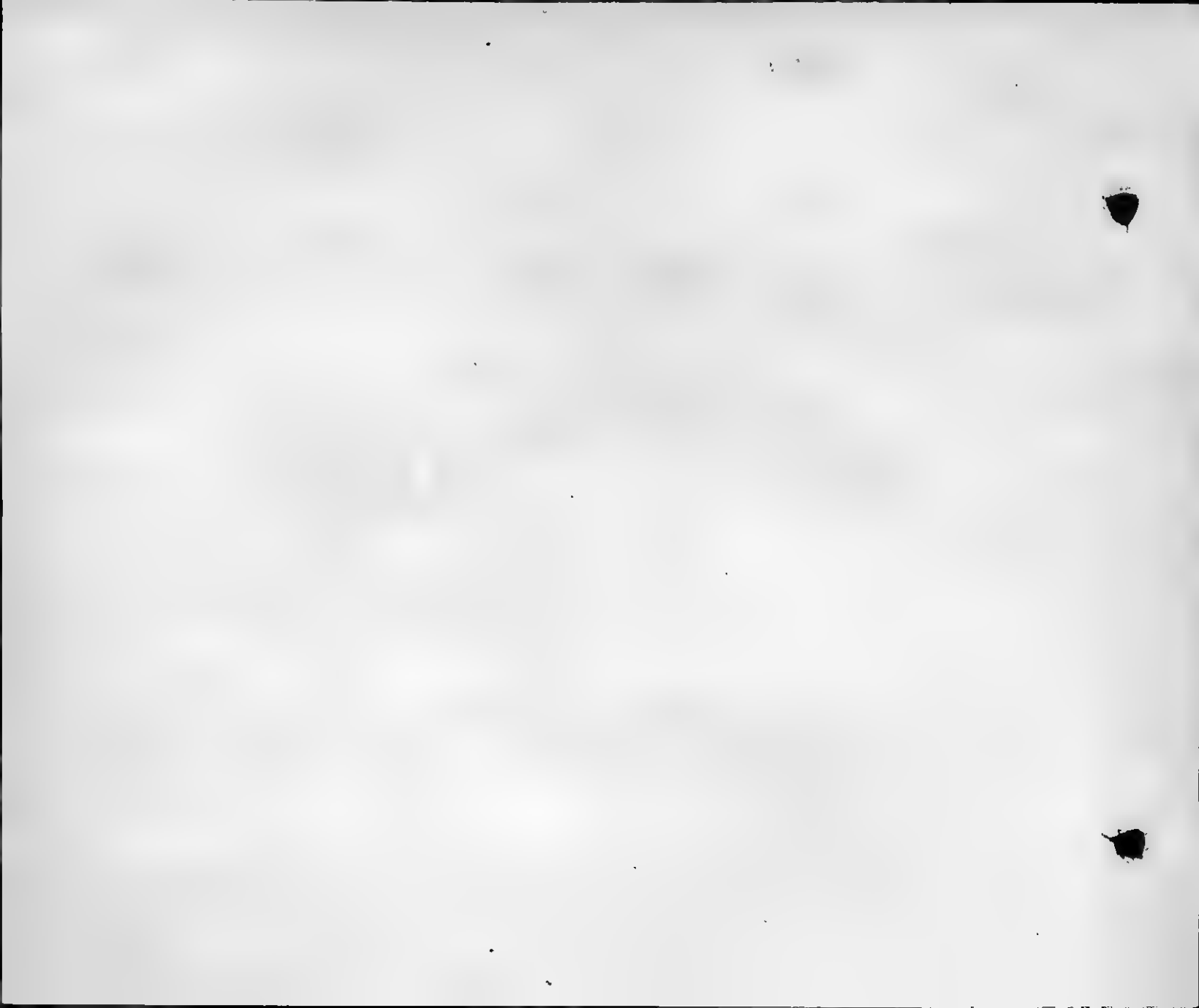
01293

01276

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in 1b <u>2 wks.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> R# <u>2</u> d. STREET ADDRESS <u>PEMBERTON DRIVE</u>	
3. NAME OF DECEASED (Type or print) <u>MAIR ABBOTT CUIVER</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Female</u> 6. COLOR OR RACE <u>white</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/20/1881</u> 9. AGE (In years last birthday) <u>80</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MERRILL ABBOTT</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		14. MOTHER'S MAIDEN NAME <u>LILLY HUGHES</u> 16. SOCIAL SECURITY NO. <u>NONE</u> 17. INFORMANT <u>L. GORDY CUIVER, SAME</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> (b) <u>Coronary Thrombosis</u> (c) <u>Arteriosclerotic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>42 hrs.</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u> 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1956</u> to <u>Jan. 28, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 28, 1962</u> and that death occurred at <u>11:45 AM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill Jr.</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. ADDRESS <u>PINE BLUFF RD, Salisbury, Md.</u>	
22c. PHYSICIAN'S NAME (Type) <u>THOMAS C. HILL JR.</u>		22d. DATE SIGNED <u>1/28/62</u>	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify) <u>BURIAL</u> <u>1/31/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 31 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanna</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01294 Item #8 - Film 3305 - 1/24/62-1116

1. PLACE OF DEATH
a. COUNTY Wicomico **MARYLAND**
b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) Salisbury
c. LENGTH OF STAY IN b DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital

2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Wicomico
c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) X Quantico
d. STREET ADDRESS _____

e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print) Charles T. Dashiell
First Middle Last

4. DATE OF DEATH JANUARY 17 1962
Month Day Year

5. SEX Male 6. COLOR OR RACE White 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH 8/9/1916 9. AGE (In years if under 1 year, if under 24 hrs. last birthday Months Days Hours Min.) 45 Yrs.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer 10b. KIND OF BUSINESS OR INDUSTRY Own Farm 11. BIRTHPLACE (County & State or foreign country) Maryland 12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME Charles R. Dashiell 14. MOTHER'S MAIDEN NAME Sally Jane Darby

15. WAS DECEASED EVER IN U.S. ARMED FORCES? No 16. SOCIAL SECURITY NO. 215-20-0213 17. INFORMANT Charles T. Dashiell, Quantico, Md. Address _____

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Hemorrhage
DUE TO (b) Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. IX
DUE TO (c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) _____

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____

21. I certify that (I) (this hospital) attended the deceased from JUNE 1958 to JAN. 17, 1961, that (I) (we) last saw the deceased alive on 19, and that death occurred at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE Thomas C. Hill Jr. M.D. 22b. DATE SIGNED 1/17/62
22c. PHYSICIAN'S NAME (Type) _____ 22d. ADDRESS Pine Bluff Road, Salisbury, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial 23b. DATE THEREOF 1/19/62 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Cemetery 23d. LOCATION (City, town or county) Salisbury (State) Md.

24. FUNERAL DIRECTOR'S SIGNATURE W. J. Bivale, Md. ADDRESS _____ 25a. REC'D BY REGISTRAR JAN 22 '62 25b. REGISTRAR'S SIGNATURE Thos S. Hunter

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VR A15 (4)
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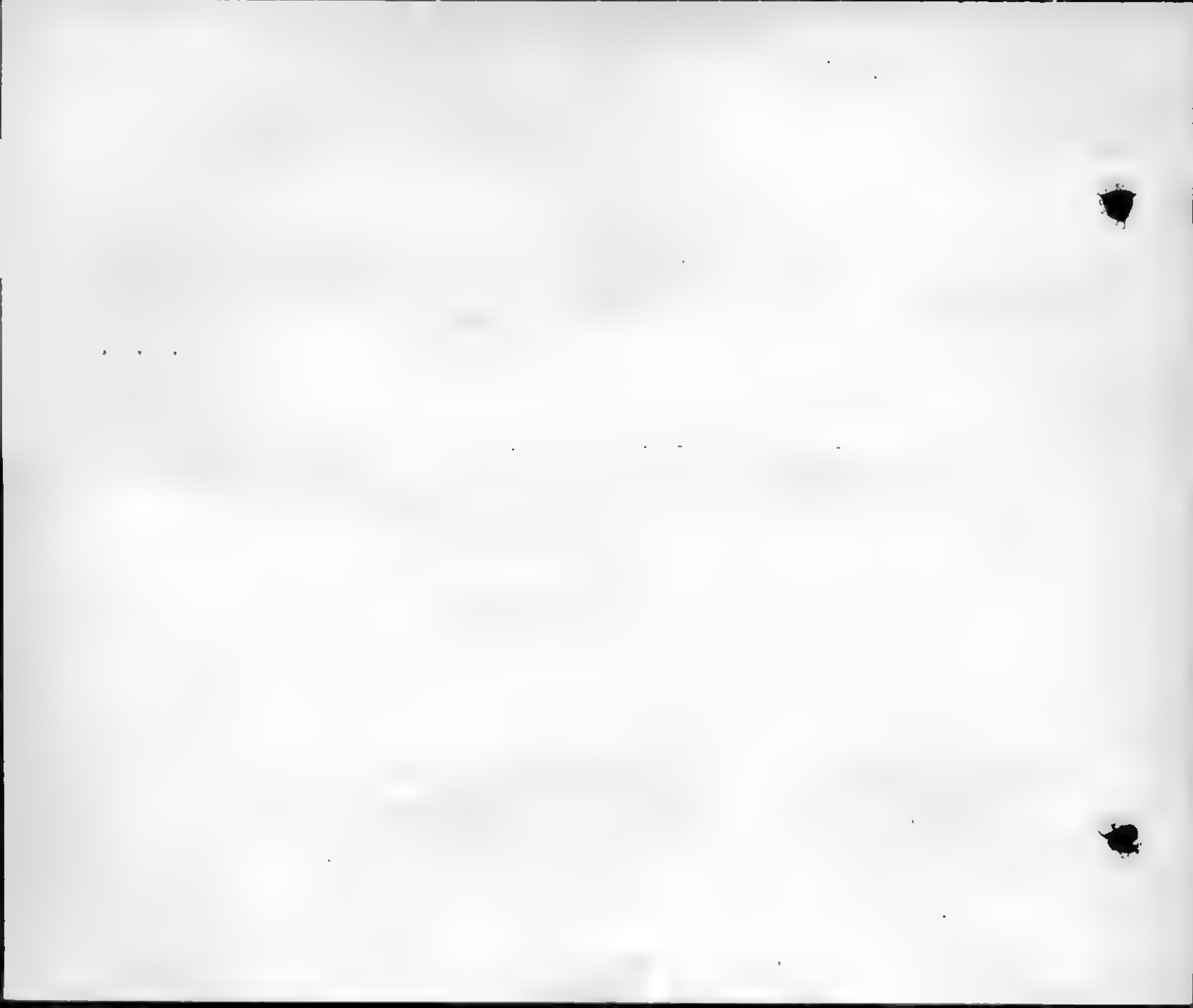
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use at the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01295

01278

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b Months			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First EDWARD Middle BREARWOOD Last DASHIELL				4. DATE OF DEATH Month January Day 31 Year 1962			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2/13/1898		9. AGE (In years last birthday) 63 yrs.	10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Accountant		10b. KIND OF BUSINESS OR INDUSTRY Electrical Utility		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Andrew J. Dashiell				14. MOTHER'S MAIDEN NAME Laura Newton			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 214-10-7958		17. INFORMANT Mrs. Edward Dashiell, Same Address			
18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c)} PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial infarct, acute 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 1961 to 1-31 1962 that (I) (we) last saw the deceased alive on 1-31 1962 and that death occurred at 8:00 PM from the causes and on the date stated above							
22a. SIGNATURE William B. Ellis Jr.				22b. DATE SIGNED 2-2-62			
22c. PHYSICIAN'S NAME (Type) WILBUR B. ELLIS Jr.				22d. ADDRESS Medical Center, Salisbury MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 2-3-1962		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland				25a. REC'D BY REGISTRAR Feb 6 '62		25b. REGISTRAR'S SIGNATURE Chas. S. Thomas	

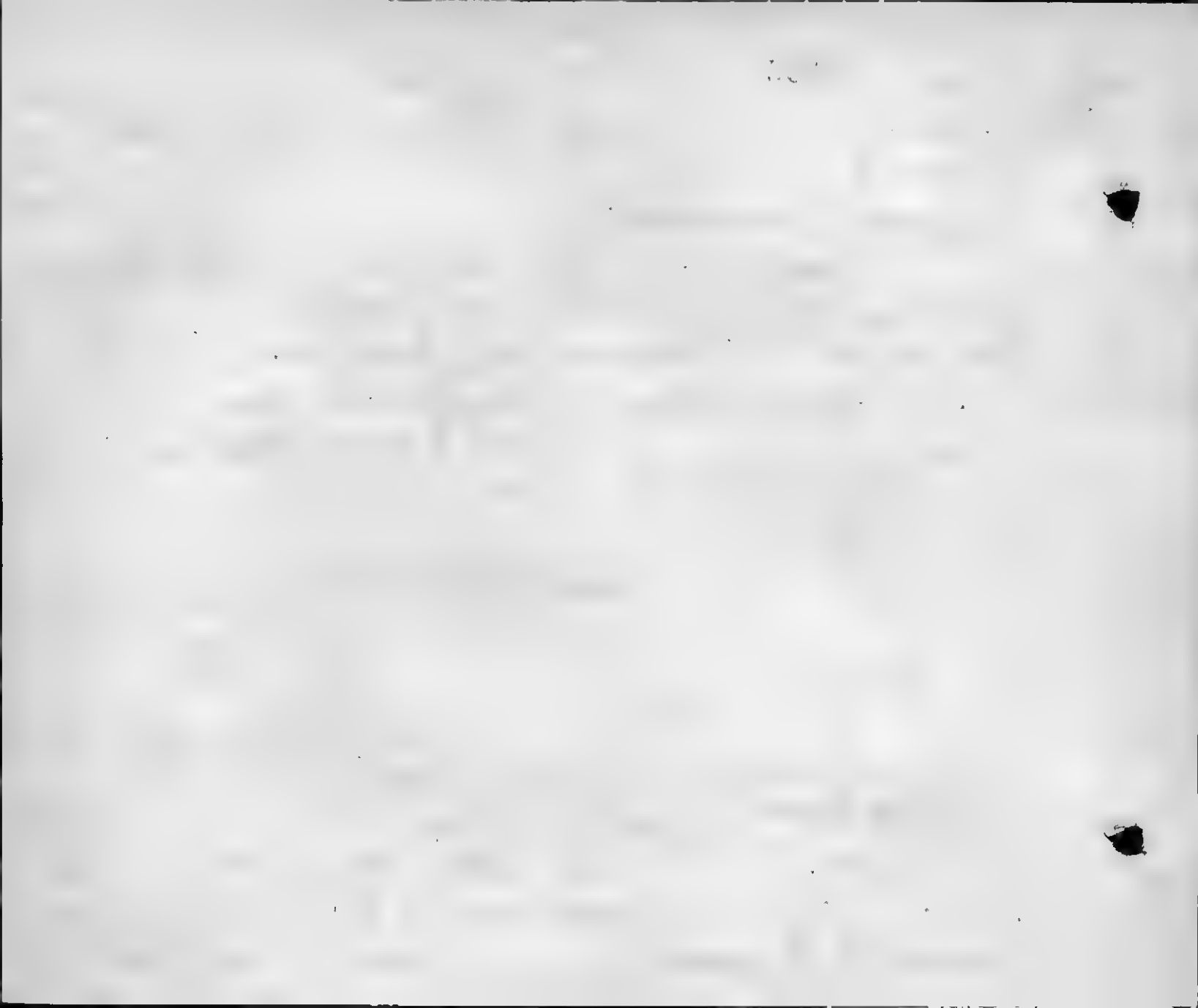


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01296
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institutional: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>W Somerset</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CHAMP</u> d. STREET ADDRESS <u>CHAMP</u>	
3. NAME OF DECEASED (Type or print) <u>Nellie W. DASHIELL</u>		4. DATE OF DEATH <u>JANUARY 20, 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 5, 1896</u>
9. AGE (In years last birthday) <u>65</u> yrs		10. IF UNDER 1 YEAR: Months <u>4</u> Days <u>3</u> Hours <u>1</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		12. BIRTHPLACE (County & State, or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>Byard Thomas West</u>		14. MOTHER'S MAIDEN NAME <u>Hester Phippin</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>Harry T. West, Champ, Md.</u>	
17. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Liver Carcinoma</u> DUE TO (b) <u>with Acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Contrib. Diabetes Mellitus</u> DUE TO (c) <u>Diabetes Mellitus</u>		18. INTERVAL BETWEEN ONSET AND DEATH <u>4 mos</u> <u>3 mo</u> <u>1 yr</u>	
19. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY: Hour <u>19</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED: While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/15, 1962</u> to <u>1/20, 1962</u> that (I) (we) last saw the deceased alive on <u>JAN. 20, 1962</u> , and that death occurred at <u>10:30 PM</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>W B Smith</u> M.D.		22b. DATE SIGNED <u>1/20/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Wm. B. Smith</u>		22d. ADDRESS <u>Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/23, 62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Oriole Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Oriole, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Leven R. Wilson</u>		25a. REC'D BY REGISTRAR <u>DATE JAN 25 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>C. H. S. K...</u>			



MARYLAND AND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01297

CERTIFICATE OF DEATH

012984

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Willards</u> c. LENGTH OF STAY IN (b) <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>XX</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Willards</u> d. STREET ADDRESS <u>XX</u>			
3. NAME OF DECEASED (Type or print) <u>George Edward Davis</u>				4. DATE OF DEATH Jan. 27, 1962 19			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 18, 1882</u> 79 yrs	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Retired</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>	
13. FATHER'S NAME <u>George E. Davis</u>				14. MOTHER'S MAIDEN NAME <u>Millie Dishroon</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>XX</u>				16. SOCIAL SECURITY NO. <u>217-36-1562</u>		17. INFORMANT <u>Gladys Combs Willards, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c)				INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour <u>9</u> p.m. Month, Day, Year <u>19</u>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan. 26, 1962 to Jan. 27, 1962, that (I) (we) last saw the deceased alive on Jan. 27, 1962, and that death occurred at 7 P.M. from the causes and on the date stated above.							
22a. SIGNATURE <u>Frank Lewis</u>				22b. DATE 5 GND			
22c. PHYSICIAN'S NAME (Type) <u>Willards Maryland</u>				22d. ADDRESS <u>Willards Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/30/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Hope</u>		23d. LOCATION (City, town or county) (State) <u>Willards, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Selbyville, Del.</u>				25a. REC'D BY REGISTRAR DATE <u>Feb 1 1962</u>			
25b. REGISTRAR'S SIGNATURE <u>Arthur L. House</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death. Then please remove carbon papers, pages 1 and 2, and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
 15M 9/60

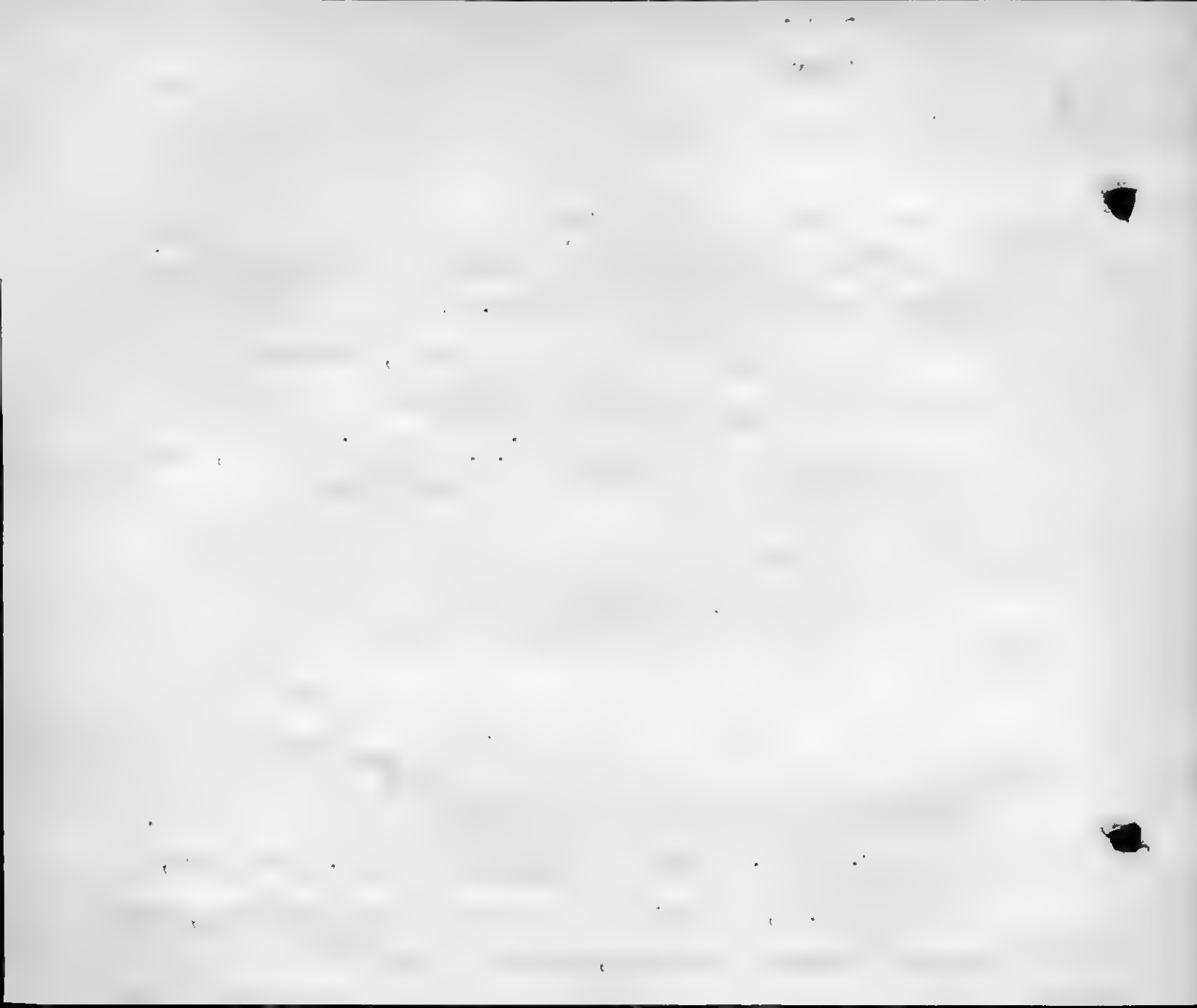


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>402 Patterson Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>ELLEN ELIZABETH Disharoon</u>				4. DATE OF DEATH <u>JANUARY 25 1962</u>				5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>Sept. 16, 1910</u> 9. AGE (In years last birthday) <u>51</u> yrs. 10. KIND OF BUSINESS OR INDUSTRY <u>House Work at Home</u> 11. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>			
13. FATHER'S NAME <u>John Parker Short</u>				14. MOTHER'S MAIDEN NAME <u>Harriett Shaw</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> 16. SOCIAL SECURITY NO _____ 17. INFORMANT <u>Mrs. Charlotte E. Morris (Daughter)</u> <u>R.D. # 1 Parsonsborg, Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.1 DUE TO _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>diabetes mellitus</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u> 20c. TIME OF INJURY Month <u>1</u> Day <u>29</u> Year <u>1962</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____ 20f. (City or town) _____ (County) _____ (State) _____											
21. I certify that (I) (this hospital) attended the deceased from <u>1/29/62</u> 1962 to <u>1/24/62</u> that (I) (we) last saw the deceased alive on <u>1/29/62</u> and that death occurred at <u>10 AM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Earl M. Beardsley</u> 22b. DATE SIGNED <u>Jan. 26 1962</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Earl M. Beardsley</u> 22d. ADDRESS <u>Maryland Ave. Salisbury, Maryland</u> 22e. MED. PHYS. <input checked="" type="checkbox"/> 22f. MED. DIRECTOR <input type="checkbox"/> 22g. STAFF PHYS. <input type="checkbox"/>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan. 27, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u> 23d. LOCATION (City, town or county) <u>Salisbury, Maryland</u> (State) _____											
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLIOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u> 25a. REC'D BY REGISTRAR <u>JAN 30 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>											



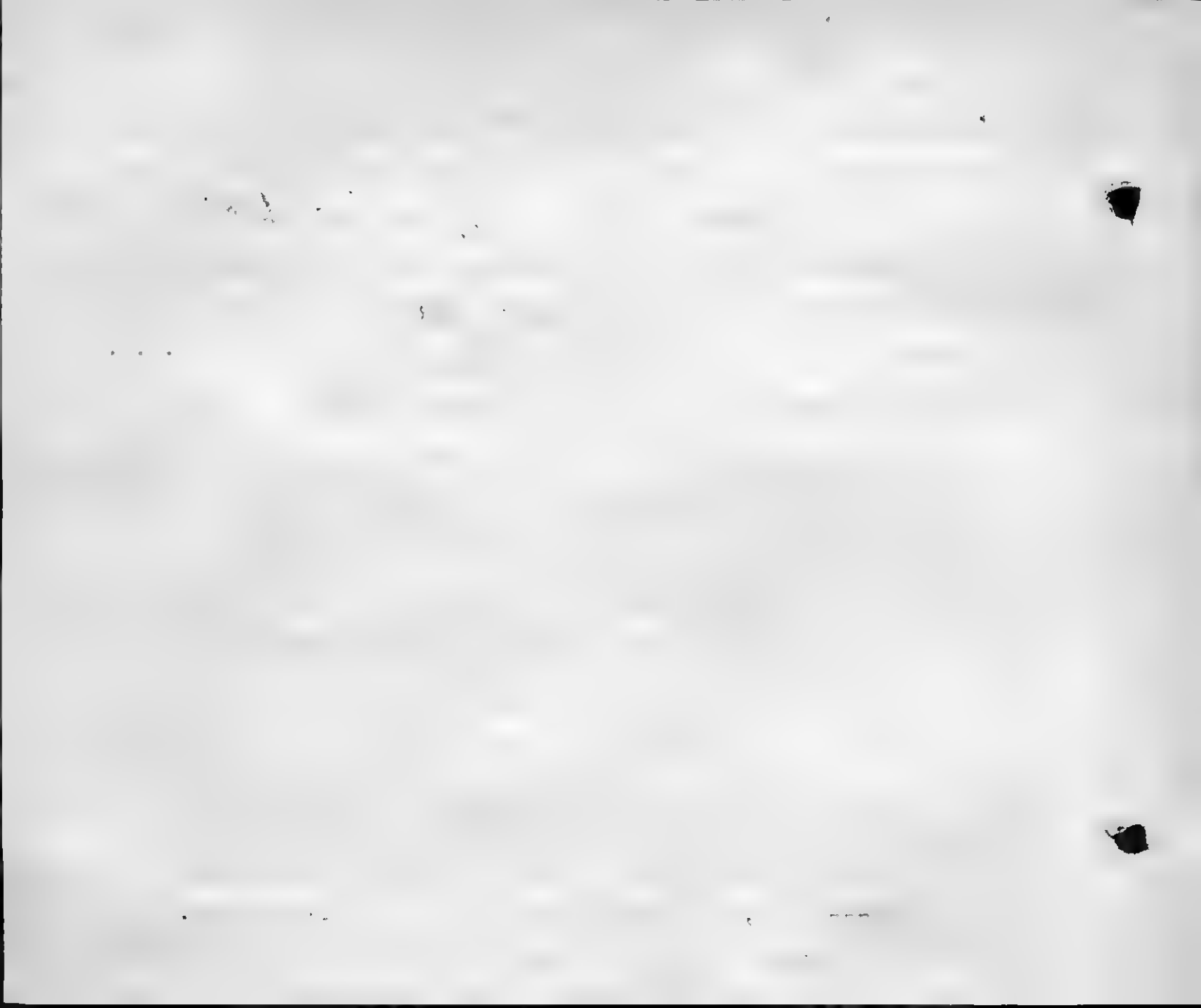
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01299 CERTIFICATE OF DEATH 01282

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>109 Jenkins Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>EMMA</u>		4. DATE OF DEATH January 17 1962		5. SEX <u>Female</u> 6. COLOR OR RACE <u>Negro</u>			
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>April 10, 1911</u>		9. AGE (In years last birthday) <u>50</u> yrs 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>house wife</u>		11. BIRTHPL. <u>Florida</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Wheel Austin</u> 14. MOTHER'S MAIDEN NAME <u>Hattie Austin</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>1-3-68-100000-1</u> 17. INFORMANT <u>Charles Harmon 109 Morris Lane</u> Address <u>Salisbury</u>			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute bronchitis</u> DUE TO <u>500X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>500X</u> DUE TO (c) <u>500X</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>acute heart failure - H. influenza meningitis</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Month, Day, Year <u>1/17/62</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>12/24/61</u> 20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>Md.</u>							
21. I certify that (I) (this hospital) attended the deceased from... <u>12/24/61</u> to... <u>1/17/62</u> that (I) (we) last saw the deceased alive on... <u>1/17/62</u> and that death occurred at... <u>2:25 PM</u> from the causes and on the date stated above.							
22a. SIGNATURE <u>Carl M. Fendley</u> 22b. DATE SIGNED <u>1/19/62</u>				22c. PHYSICIAN'S NAME (Type) <u>Carl M. Fendley</u> 22d. ADDRESS <u>Salisbury Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u> 23b. DATE THEREOF <u>22/ 62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres</u> 23d. LOCATION (City, town or county) <u>Salisbury Md.</u> (State) <u>Md.</u>		24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur E. Stewart</u> 25a. REC'D BY REGISTRAR <u>JAN 22 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur E. Stewart</u>					



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01300

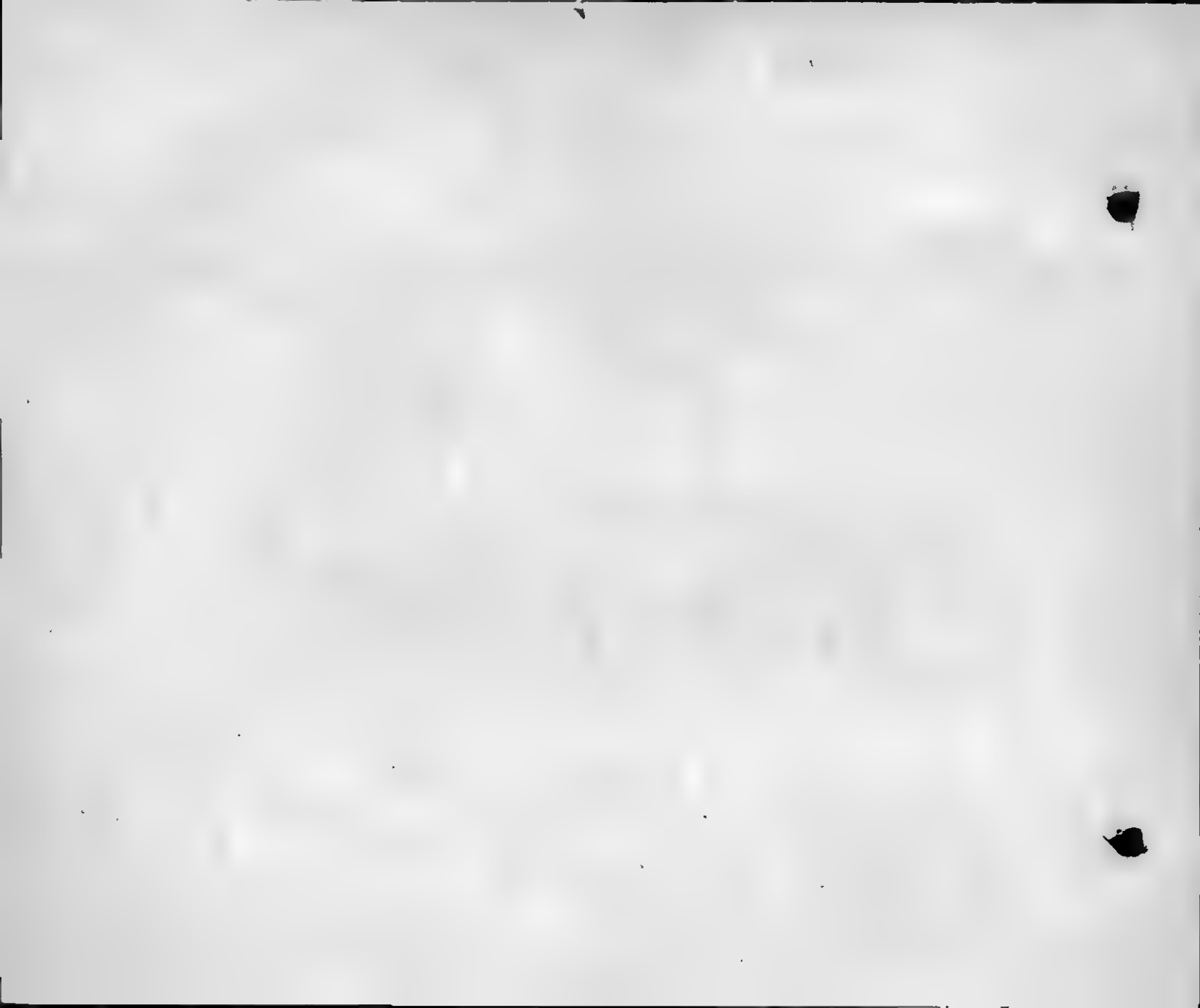
CERTIFICATE OF DEATH

Item 4, Film G-300 1/30/62 ecc.

01283

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>			2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>MARDELA SPRINGS</u> d. STREET ADDRESS <u>INTERIOR</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) <u>William R. English</u> First Middle Last			4. DATE OF DEATH <u>JANUARY 19 1962</u> Month Day Year		
5. SEX <u>MALE</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH <u>April 12, 1914</u> Yrs. Months Days		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> 11. BIRTHPLACE (County & State, or foreign country) <u>MD</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>			13. FATHER'S NAME <u>William T. English</u> 14. MOTHER'S MAIDEN NAME <u>Dora Rusick</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> 16. SOCIAL SECURITY NO. <u>216-5442</u> 17. INFORMANT <u>Mrs. Mary English - Mother</u> Address			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>420</u> DUE TO (b) <u>1</u> DUE TO (c) <u>1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arterio-sclerosis obliterans</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year <u>1-19-62</u> Hour a.m. p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>1-9-62</u> to <u>1-19-62</u>, that (I) (we) last saw the deceased alive on <u>1-19-62</u>, and that death occurred at <u>6:00 P.M.</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>William R. English</u> 22c. PHYSICIAN'S NAME (Type)			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS 22b. DATE SIGNED <u>1-19-62</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>1-23-62</u> 23b. DATE THEREOF			23c. NAME OF CEMETERY OR CREMATORY <u>1-23-62</u> 23d. LOCATION (City, town or county) (State)		
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. H. ...</u> 25a. REC'D BY REGISTRAR <u>JAN 25 '62</u> 25b. REGISTRAR'S SIGNATURE <u>C. ...</u>			25c. NAME OF CEMETERY OR CREMATORY <u>1-23-62</u> 25d. LOCATION (City, town or county) (State)		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

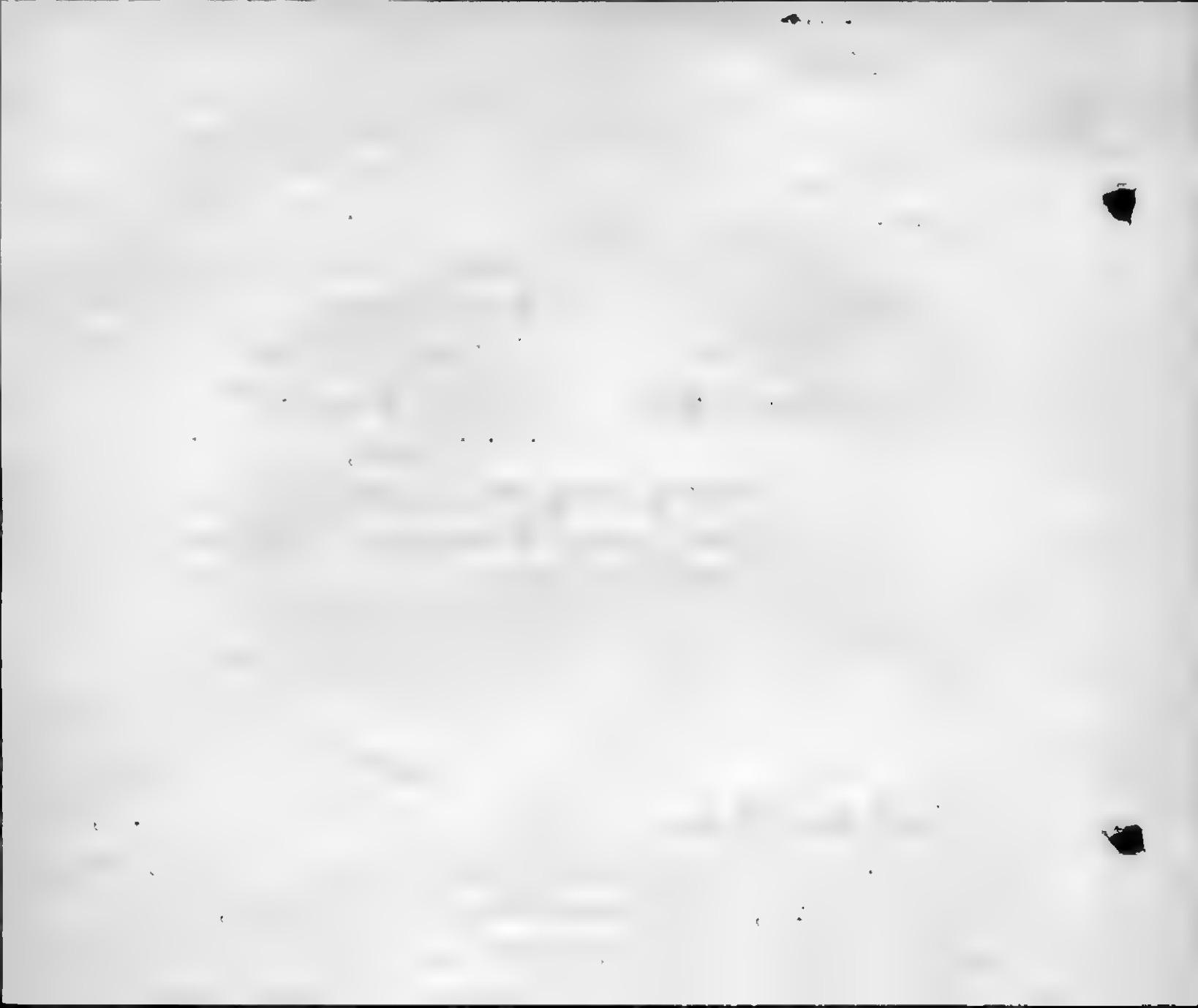
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01301

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01284

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN TB d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>733 S. Division St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>BETTY NMI ENNIS</u>		4. DATE OF DEATH <u>JANUARY 22 1962</u> Month <u>January</u> Day <u>22</u> Year <u>1962</u>	
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>Baby</u>		8. DATE OF BIRTH <u>JANUARY 22 1962</u> 9. AGE (In years last birthday) <u>0</u> yrs. Months <u>0</u> Days <u>0</u> Hours <u>7</u> Min. <u>38</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (Country & State, or foreign country) <u>Wicomico MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>WILLIAM JAMES ENNIS</u>		14. MOTHER'S MAIDEN NAME <u>PATRICIA ANN Nibblett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>		16. SOCIAL SECURITY NO. <u>INFORMANT</u> Mr. Wm. J. Ennis (Father) <u>733 S. Division St Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple congenital anomalies, including</u> DUE TO (b) <u>Hydrocephalus, meningocele, complete</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>spina bifida</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1945</u> to <u>1962</u> , that (I) (we) last saw the deceased alive on <u>12 PM</u> , 19 <u>62</u> , and that death occurred at <u>12 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Robert Lee Baker</u>		22b. DATE SIGNED <u>Jan. 22, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert Lee Baker</u>		22d. ADDRESS <u>Medical Center Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 23, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		25. REC'D BY REGISTRAR <u>JAN 26 '62</u>	
ADDRESS <u>SALISBURY, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kiser</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01302

01285

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>1 hr.</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>5-2 Liberty</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																			
3. NAME OF DECEASED (Type or print) First <u>Levi</u> Middle <u>Edward</u> Last <u>EURE</u>				4. DATE OF DEATH Month <u>JANUARY</u> Day <u>24</u> Year <u>1962</u>																			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9/21/1907</u>		9. AGE (In years last birthday) <u>54</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>															
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumberman Timber Cutter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>N.C.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>N.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>													
13. FATHER'S NAME <u>J. J. Eury</u>				14. MOTHER'S MAIDEN NAME <u> </u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>yes - World War II</u>															
16. SOCIAL SECURITY NO. <u> </u>				17. INFORMANT <u>Marie Heath Eury, Salisbury, Md.</u>				18. CAUSE OF DEATH (Enter only one cause possible for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause last. DUE TO (c) <u> </u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>											
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u> </u> p.m. <u> </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>				20f. (City or town) (County) (State) <u>Salisbury, Md.</u>											
21. I certify that (I) (this hospital) attended the deceased from <u>1-24, 1962</u> to <u>1-24, 1962</u> that (I) (we) last saw the deceased alive on <u>1-24, 1962</u> and that death occurred at <u>8:30 AM</u> from the causes and on the date stated above.																							
22a. SIGNATURE <u>Philip A. Trsten</u>						22b. DATE SIGNED <u> </u>																	
22c. PHYSICIAN'S NAME (Type or print) <u>Philip A. Trsten</u>						22d. ADDRESS <u>Salisbury, Md.</u>																	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE THEREOF <u>1/27/62</u>				23c. NAME OF CEMETERY OR CREMATORY <u>Wic. Mem. Park Cem. Salisbury, Md.</u>				23d. LOCATION (City, town or county) (State) <u>Salisbury, Md.</u>											
24 FUNERAL DIRECTOR'S SIGNATURE <u> </u>						25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u> </u>																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part I may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

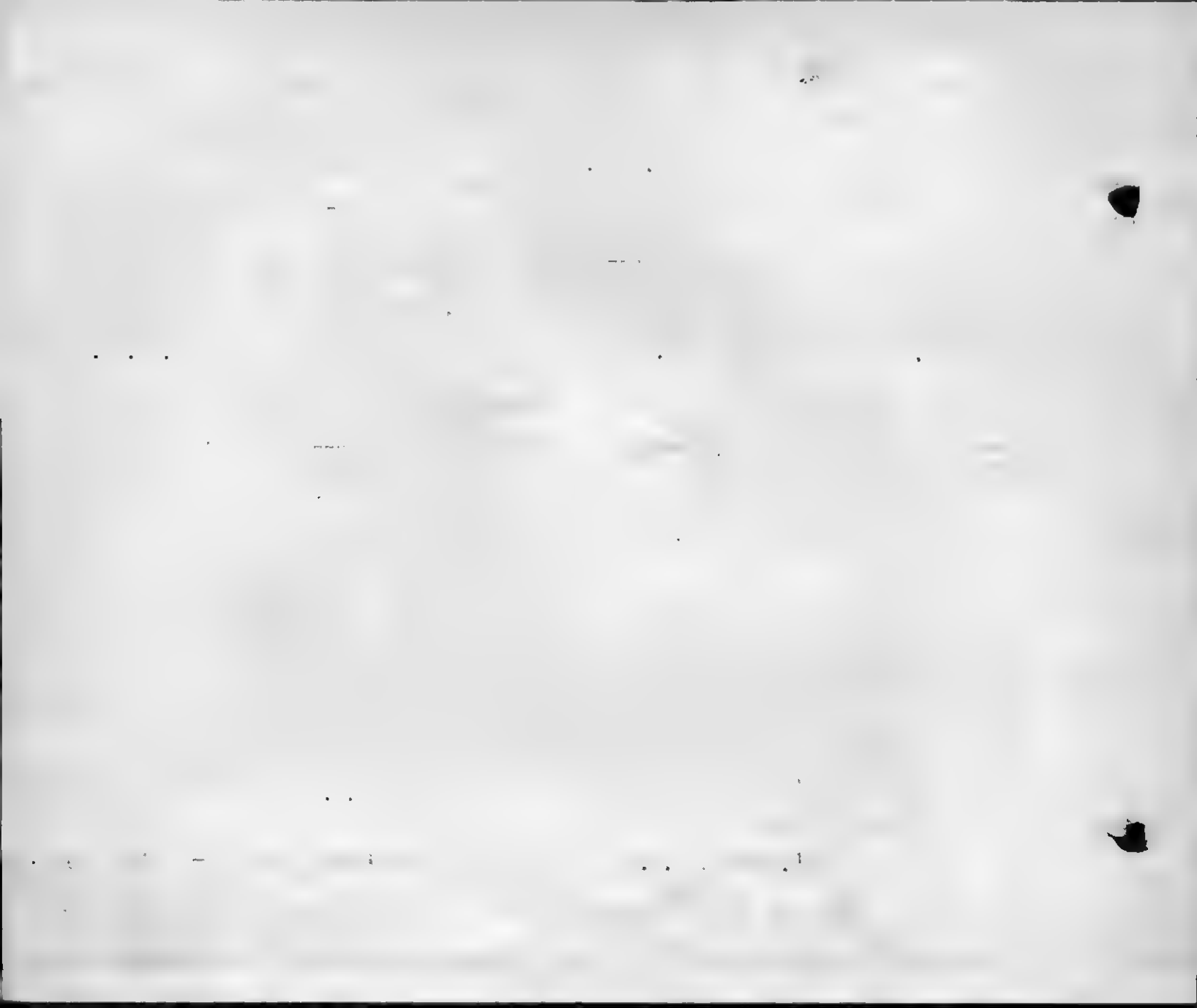
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01303

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01986

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Queen Anne</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Millington</u>	
c. LENGTH OF STAY IN 1b <u>4 Yrs. 5 Mos. 15 Days</u>		d. STREET ADDRESS <u>17X 2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna</u> First <u>Everett</u> Middle <u>---</u> Last		4. DATE OF DEATH Month <u>January</u> Day <u>8</u> Year <u>19 62</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> B. DATE OF BIRTH <u>March 27, 1872</u>		9. AGE (In years last birthday) <u>89</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Caroline County</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Thomas Emory</u>		14. MOTHER'S MAIDEN NAME <u>CHARITY Clough</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE.</u>		17. INFORMANT <u>Hospital Records --- Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <u>Acute Myocardial Failure</u> DUE TO (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u>10 yrs.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <u>19</u> Hour a.m. <u>3</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>7/24/57</u> , 19....., to <u>1/8/62</u> , 19....., that (I) (we) last saw the deceased alive on <u>1/8/62</u> , 19....., and that death occurred at <u>8:35 P.M.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>Lee L. Lawry</u>		22b. DATE SIGNED <u>1/8/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lee L. Lawry, M.D.</u>		22d. ADDRESS <u>Deer's Head Hospital - Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>Jan. 11, 62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MASSEY CEM.</u>		23d. LOCATION (City, town or county) (State) <u>MASSEY RENT CO. Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Fellows</u>		25a. REC'D BY REGISTRAR <u>1/11/62</u>	
ADDRESS <u>Millington, Md.</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	



may be reviewed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01304

01287

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				d. STREET ADDRESS R.D.# 2 Spring Hill Road			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3 NAME OF DECEASED (Type or print) First SADIE Middle ELLEN Last FLEMING				4. DATE OF DEATH Month JANUARY Day 29 Year 1962			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH March 24, 1890	9. AGE (In years last birthday) 71 yrs	IF UNDER 1 YEAR Months 10 Days 5	IF UNDER 24 HRS. Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None		11 BIRTHPLACE (State or foreign country) Tarrall Co. N. Carolina		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Mathis Levy Tarkengton				14 MOTHER'S MAIDEN NAME Frances Elizabeth Brickhouse			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 		17. INFORMANT Mr. H. J. Forbes (Son) Address R.D.# 2 Spring Hill Rd Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: 332 Cerebral Thrombosis IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) (c) INTERVAL BETWEEN ONSET AND DEATH 17 hours.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral Hypertension							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A					
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 p. m. 		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State) 	
21. I certify that (I) (this hospital) attended the deceased from 10/5 to 1/27 that (I) (we) last saw the deceased alive on 1/29 19 62 and that death occurred on 1/29 from the causes and on the date stated above.							
22a. SIGNATURE Earl M. Beadsley				M.D. ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED Jan. 30 / 1962	
22c. PHYSICIAN'S NAME (Type) Dr. Earl M. Beadsley				22d. ADDRESS Md Ave. Salisbury, Maryland			
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Feb. 1, 1962		23c. NAME OF CEMETERY OR CREMATORY Spring Hill Memory Gardens		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE FEB 1 '62	
				25b. REGISTRAR'S SIGNATURE Arthur E. Harris			

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01305 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

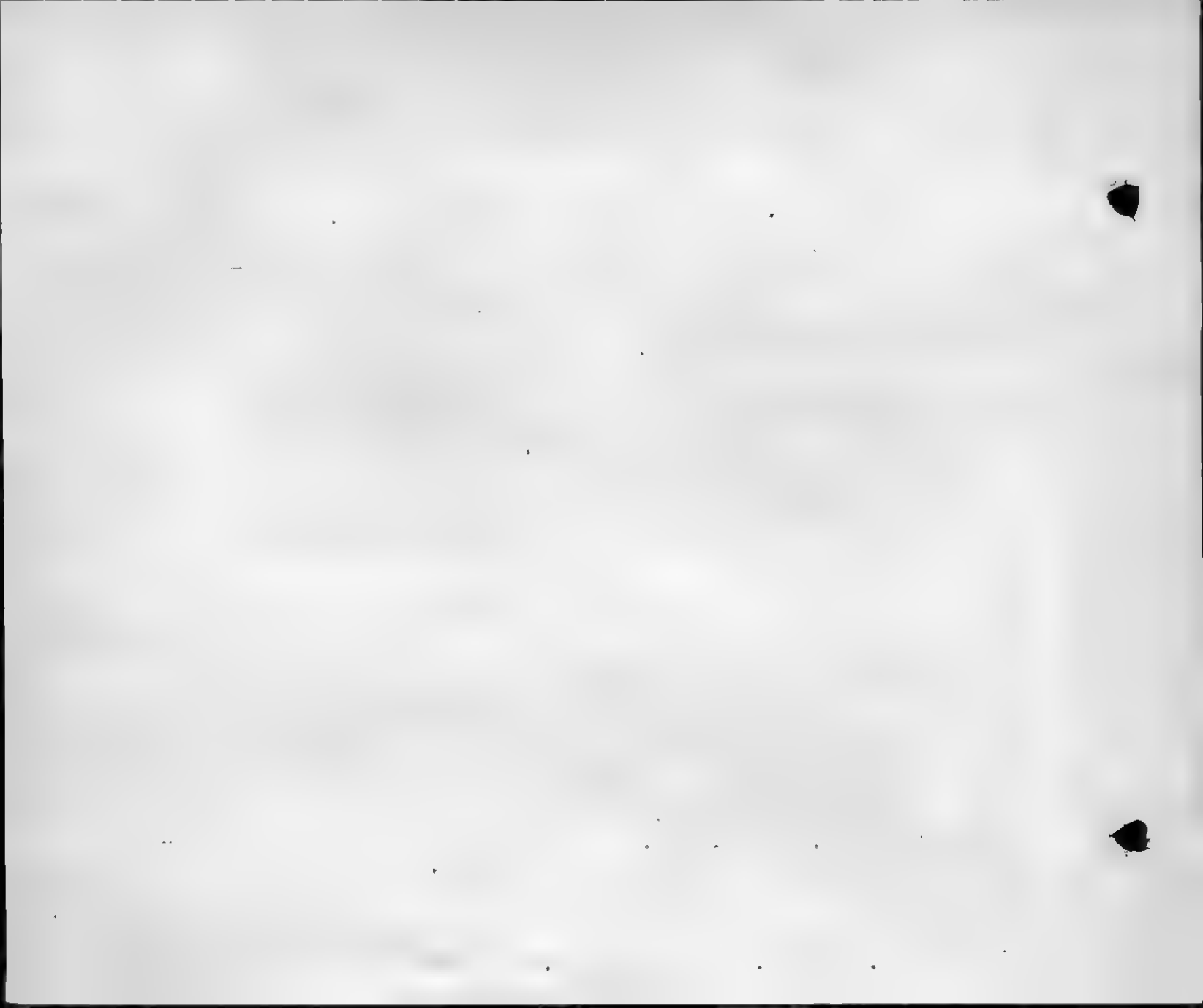
01988

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

M

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Mineola Ave. Route # 2</u>		2. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Mineola Ave. Route # 2</u>	
3. NAME OF DECEASED (Type or print) <u>William R Fletcher</u>		4. DATE OF DEATH <u>1-8-62</u>	
5. SEX <u>M</u>		6. COLOR OR RACE <u>AA</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>9-22-04</u>	
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	
11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>West Gunby</u>		14. MOTHER'S MAIDEN NAME <u>Emma Fletcher</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Margaret Fletcher, Salisbury, Md</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Malnutrition</u> (b) <u>Carcinoma of the esophagus</u> (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> (b) <u> </u> (c) <u> </u>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>Months</u>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> e.m. <u> </u> p.m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. <u>Natural causes</u> <input checked="" type="checkbox"/> <u>Accident</u> <input type="checkbox"/> <u>Suicide</u> <input type="checkbox"/> <u>Homicide</u> <input type="checkbox"/> <u>Undetermined manner</u> <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>		DATE SIGNED <u>1-10-62</u>	
EXAMINER'S NAME (Type) <u>407 Camden Avenue Salisbury, Md.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>1-12-62</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Cemetery</u>		22d. LOCATION (City, town, or country) <u>Salisbury Wicomico Md.</u>	
23. FUNERAL DIRECTOR <u>Thornton B. Jolley, Salisbury, Md.</u>		24a. REC'D BY REGISTRAR <u>JAN 15 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanes</u>		DATE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01306

41984

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>10 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Poninsula Gen. Hosp.</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Delaware</u> b. COUNTY <u>Swiss</u> c. CITY OR TOWN (If out of corporate limits, write RURAL and give nearest town) <u>Milletsboro</u> d. STREET ADDRESS <u>46x3</u>	
3. NAME OF DECEASED (Type or print) <u>John Walls</u> First Middle Last		4. DATE OF DEATH Month Day Year <u>January 16 1962</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>APRIL-14-1905</u> 9. AGE (in years last birthday) <u>56</u> yrs. IF UNDER YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>General work construction</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN WALLS FLOOD SR.</u>		14. MOTHER'S MAIDEN NAME <u>ANNA NORA ROGERS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>-</u> 16. SOCIAL SECURITY NO. <u>221-16-7010</u>		17. INFORMANT <u>MARGARET WOOTTEN</u> Address <u>SEAFORD DEL.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420</u> <u>Myocardial Infarct, acute</u> DUE TO (b) <u>12 hours</u> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) <u>12 hours</u>		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>1-16-1962</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (1) (this hospital) attended the deceased from 1-16-1962 to 1-16-1962, that (1) (we) last saw the deceased alive on 1-16-1962, and that death occurred at 3:20 PM, from the causes and on the date stated above.			
22a. SIGNATURE <u>William B. Ellis Jr.</u> M.D.		22b. DATE SIGNED <u>1-16-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Walton & Gray</u>		22d. ADDRESS <u>Frankford, Del.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1/19/62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>RED MENS CEMETERY</u>		23d. LOCATION (City, town or county) (State) <u>SELBYVILLE DEL.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walton & Gray</u>		25a. REC'D BY REGISTRAR <u>1-18-62</u> DATE	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kray</u>			



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 11 Film G305 1/23/62 iwk

CERTIFICATE OF DEATH

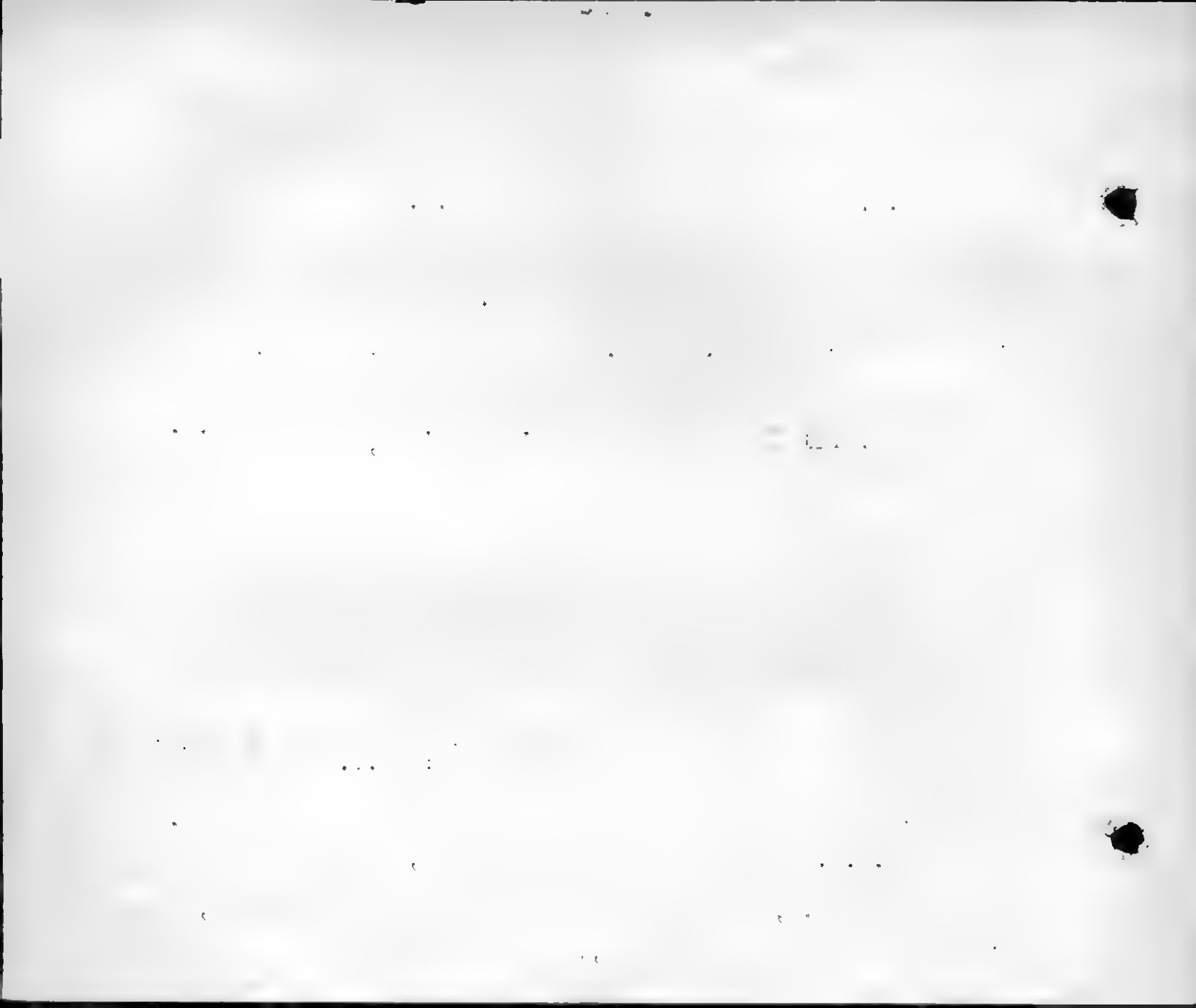
Reg. Dist. No. 111990

01307

1. PLACE OF DEATH a. COUNTY WICOMICO MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY SOMERSET			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY				c. LENGTH OF STAY IN 1b 6 weeks			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION SPRINGHILL SANITARIUM				d. STREET ADDRESS PRINCESS ANNE			
3. NAME OF DECEASED (Type or print) First DELLA Middle FORD Last e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				4. DATE OF DEATH Month JAN. Day 11 Year 1962			
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH OCT. 29, 1883	
9. AGE (In years last birthday) yrs. 78		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NONE				10b. KIND OF BUSINESS OR INDUSTRY NONE		11. BIRTHPLACE (State or foreign country) Maryland	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME ZADOC TOWNSAND				14. MOTHER'S MAIDEN NAME LAURA HASTING			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.			
17. INFORMANT EDWARD DUER EXMORE, VA.				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Thrombosis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Chronic Brain Syndrome DUE TO (c) Arteriosclerotic cerebral Vascular Disease PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Primary Hypertension INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from June , 1960, to Jan 11 , 1962, that I last saw the deceased alive on Jan 5 , 1962, and that death occurred at 12:35 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pine Bluff Road Salisbury, Maryland DATE SIGNED 1/12/62 ACTUAL SIGNATURE Thomas C. Hill, M.D. PHYSICIAN'S NAME (Type) Salisbury, Maryland							
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF -13-1962		22c. NAME OF CEMETERY OR CREMATORY ST. ANDREW CEMETERY		22d. LOCATION (City, town, or county) (State) PRINCESS ANNE, MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Lorne R. Wilson				ADDRESS PRINCESS ANNE, MD.		24a. REC'D BY REGISTRAR DATE JAN 17 '62	
24b. REGISTRAR'S SIGNATURE William J. Thomas							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 1 may be retained by the hospital or attending physician. Part 2 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

01309

CERTIFICATE OF DEATH

01292

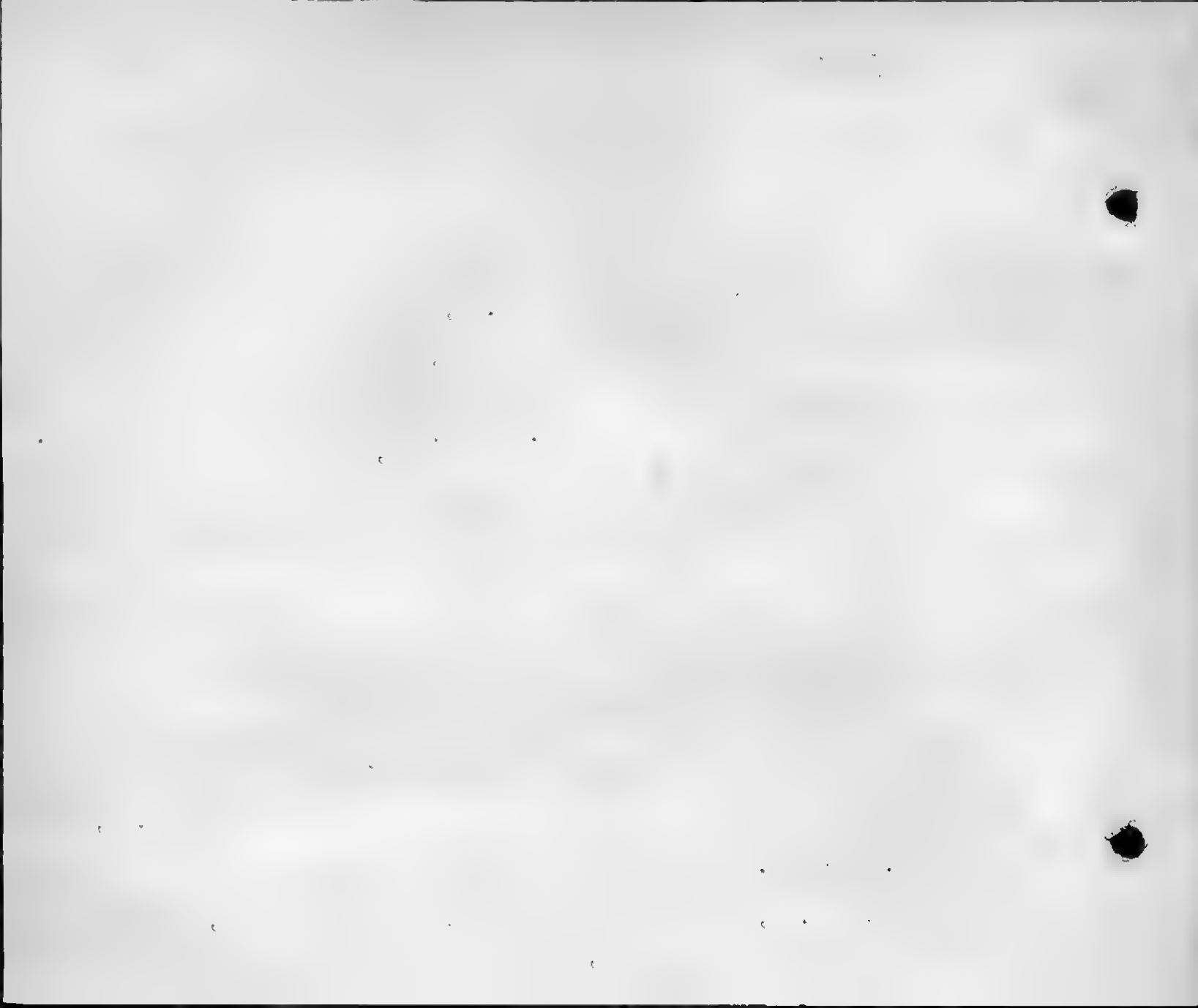
1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>1</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X FRUITLAND</u> d. STREET ADDRESS <u>SCHOOL ST.</u>			
3. NAME OF DECEASED (Type or print) <u>CHRIS JAMES GLADDEN</u>				4. DATE OF DEATH <u>JANUARY 1 1962</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>OCT 10, 1941</u>	
9. AGE (In years last birthday) <u>21</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>NONE (BABY)</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>ELBERT GLADDEN</u>				14. MOTHER'S MAIDEN NAME <u>DRUSILLA CONLEY</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Mr Elbert Gladden, Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sudden unexpected death with</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>due to</u> (b) <u>sudden onset of high fever - Probably Bacteremia</u> (c) <u>due to</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Multiple Congenital Anomalies -</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20c. TIME OF INJURY Hour a.m. <u>10/10</u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>10/10</u>		20f. (City or town) <u>10/11</u> (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/10</u> 19 <u>61</u> , to <u>10/11</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>12/31</u> 19 <u>61</u> , and that death occurred at <u>7:30</u> AM, from the causes and on the date stated above.							
22a. SIGNATURE <u>William C. Morgan</u> M.D.				22b. ADDRESS <u>SALISBURY, MARYLAND</u>			
22c. PHYSICIAN'S NAME (Type) <u>WILLIAM C. MORGAN</u>				22d. ADDRESS <u>SALISBURY, MARYLAND</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>1-2-1962</u>		23c. NAME OF CEMETERY OR CREMATORY <u>WICOMICO MEM. PK.</u>		23d. LOCATION (City, town or county) <u>SALISBURY, MARYLAND</u> (State)	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Hill J Johnson</u> ADDRESS <u>SALISBURY, MD.</u>				25a. REC'D BY REGISTRAR <u>DATE 4 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01310
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		d. STREET ADDRESS <u>404 Atlantic Ave</u>	
3. NAME OF DECEASED (Type or print) <u>Paul CLAYTON</u>		4. DATE OF DEATH <u>January 23 1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 25, 1900</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accounting (Self Employed)</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Laurel, Delaware</u>	
13. FATHER'S NAME <u>Frank Gordy</u>		14. MOTHER'S MAIDEN NAME <u>Laura Pusey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		17. INFORMANT <u>Mrs. Anne G. Gordy (Wife)</u>	
16. SOCIAL SECURITY NO. <u>162-21</u>		18. ADDRESS <u>404 Atlantic Ave. Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Hemorrhage from posterior pharynx</u> Conditions, if any, which gave rise to immediate cause (b) <u>Brachogenic Ca & metastases to</u> (a), stating the underlying cause last. (c) <u>pharynx & neck.</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u> <u>1 yr.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (we) attended the deceased from <u>Nov.</u> 19 <u>61</u> to <u>1-23</u> 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1-23</u> 19 <u>62</u> , and that death occurred at <u>11:20 PM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>George H. Henning</u>		22b. DATE SIGNED <u>Jan. 23, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. George H. Henning</u>		22d. ADDRESS <u>Fruitland, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 25, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>		23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		25a. REC'D BY REGISTRAR <u>JAN 26 '62</u>	
ADDRESS <u>SALISBURY, MARYLAND</u>		25b. REGISTRAR'S SIGNATURE <u>James L. Henning</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Nos 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

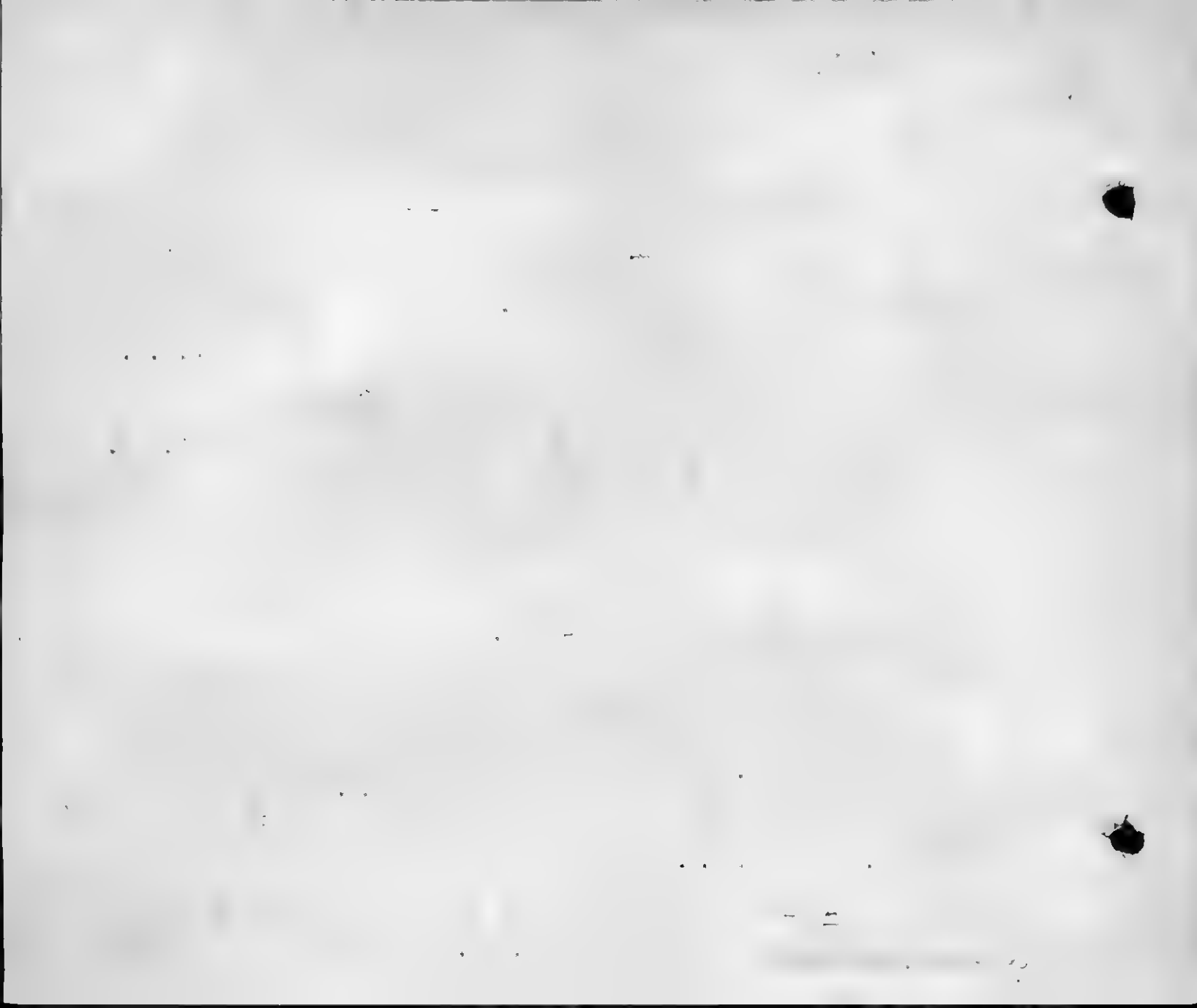
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01311

CERTIFICATE OF DEATH

01294

1. PLACE OF DEATH a. COUNTY <u>Wicomico County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>39 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset County</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> d. STREET ADDRESS <u>---</u>	
3. NAME OF DECEASED (Type or print) First <u>Susie</u> Middle <u>E.</u> Last <u>GREEN</u>		4. DATE OF DEATH Month <u>January</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 3, 1872</u>	
9. AGE (In years last birthday) <u>89</u> yrs.		10. IF UNDER 1 YEAR Months <u>---</u> Days <u>---</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>	
11. BIRTH-PLACE (County & State, or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH RUE</u>		14. MOTHER'S MAIDEN NAME <u>ELIZABETH JOHNSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO <u>HARRY HICKMAN PRINCESS ANNE, MD.</u>	
17. INFORMANT <u>HARRY HICKMAN PRINCESS ANNE, MD.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 491X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>---</u> DUE TO (c) <u>---</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e). <u>Fracture of right femur with non-union.</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>---</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/20/1961</u> , to <u>1/28/1962</u> , that (I) (we) last saw the deceased alive on <u>Jan. 28, 1962</u> , and that death occurred at <u>7:20 P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. V. Maldve</u>		22b. DATE SIGNED <u>1/29/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. V. Maldve, M.D.</u>		22d. ADDRESS <u>Deer's Head State Hospital Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1631-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>EPISCOPAL CEMETERY</u>		23d. LOCATION (City, town or county) <u>FAIRMOUNT, MARYLAND</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson</u>		25a. REC'D BY REGISTRAR <u>DATE FEB 2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>			



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

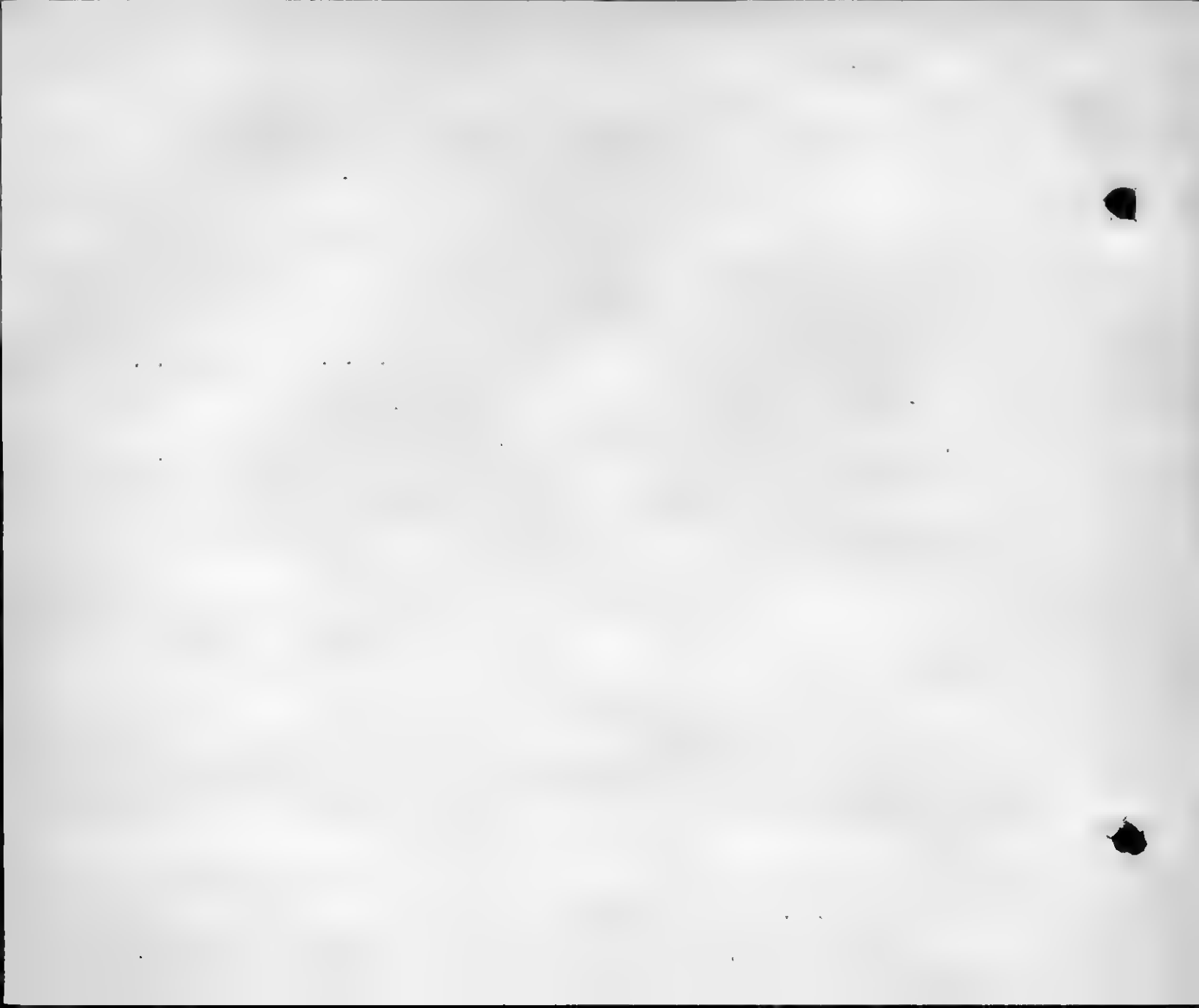
CERTIFICATE OF DEATH

01312

11995

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u> ✓ c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Cambridge, R.D. 2</u> d. STREET ADDRESS <u>Rural</u>	
3. NAME OF DECEASED (Type or print) <u>Clyde James Greenwell</u> First Middle Last		4. DATE OF DEATH Month <u>January</u> Day <u>9</u> Year <u>1962</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Aug, 17, 1880</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> IF UNDER 24 HRS.: Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer Self employed</u> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Cambridge, R.D. U.S.</u> 12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>J. Sothern Greenwell</u>		14. MOTHER'S MAIDEN NAME <u>Susan E. Wheatley</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>215-36-1537</u> 17. INFORMANT <u>Phillips S. Greenwell, Salisbury, Md.</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarct, acute</u> (b) <u>4-20</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u> </u> DUE TO <u> </u> DUE TO <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u> </u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u> 20c. TIME OF INJURY Month, Day, Year <u> </u> <u> </u> <u> </u> <u>19</u> Hour a.m. <u> </u> p.m. <u> </u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u> 20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>			
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>1-3</u> to <u>1-9</u> , 1962, that <u>(1)</u> (we) last saw the deceased alive on <u>1-9</u> , 1962, and that death occurred at <u>1:15 P.</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>William R. Ellis Jr.</u> 22c. PHYSICIAN'S NAME (Type)		22b. DATE SIGNED <u>1-9-62</u> 22d. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Jan. 12, 1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lady Good Counsel Churchyard Secretary, Md.</u>		23d. LOCATION (City, town or county) <u> </u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Kenneth R. Shouse</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 15 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur J. Hanks</u>		25c. REGISTRAR'S NAME	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

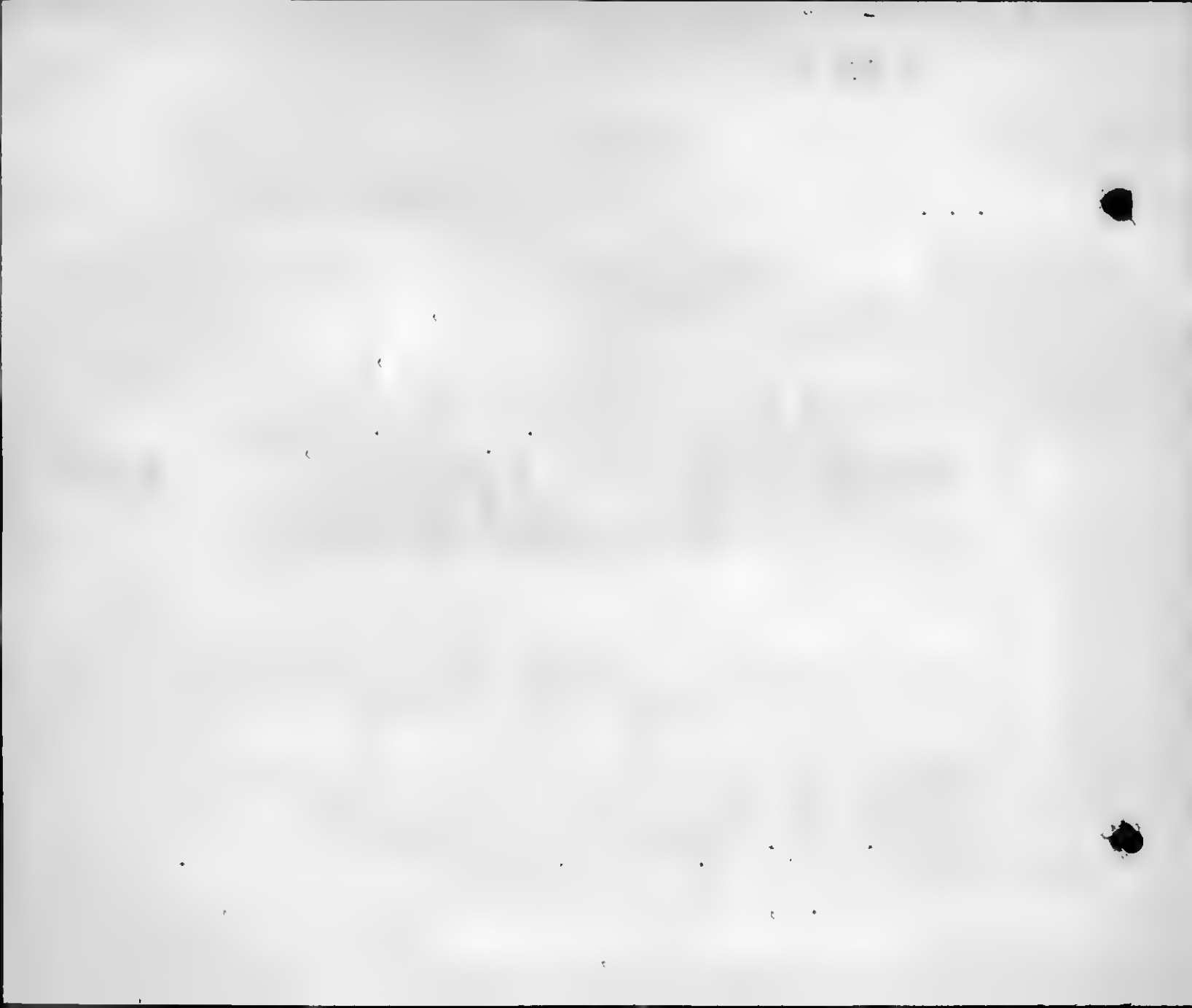
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01313 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01296

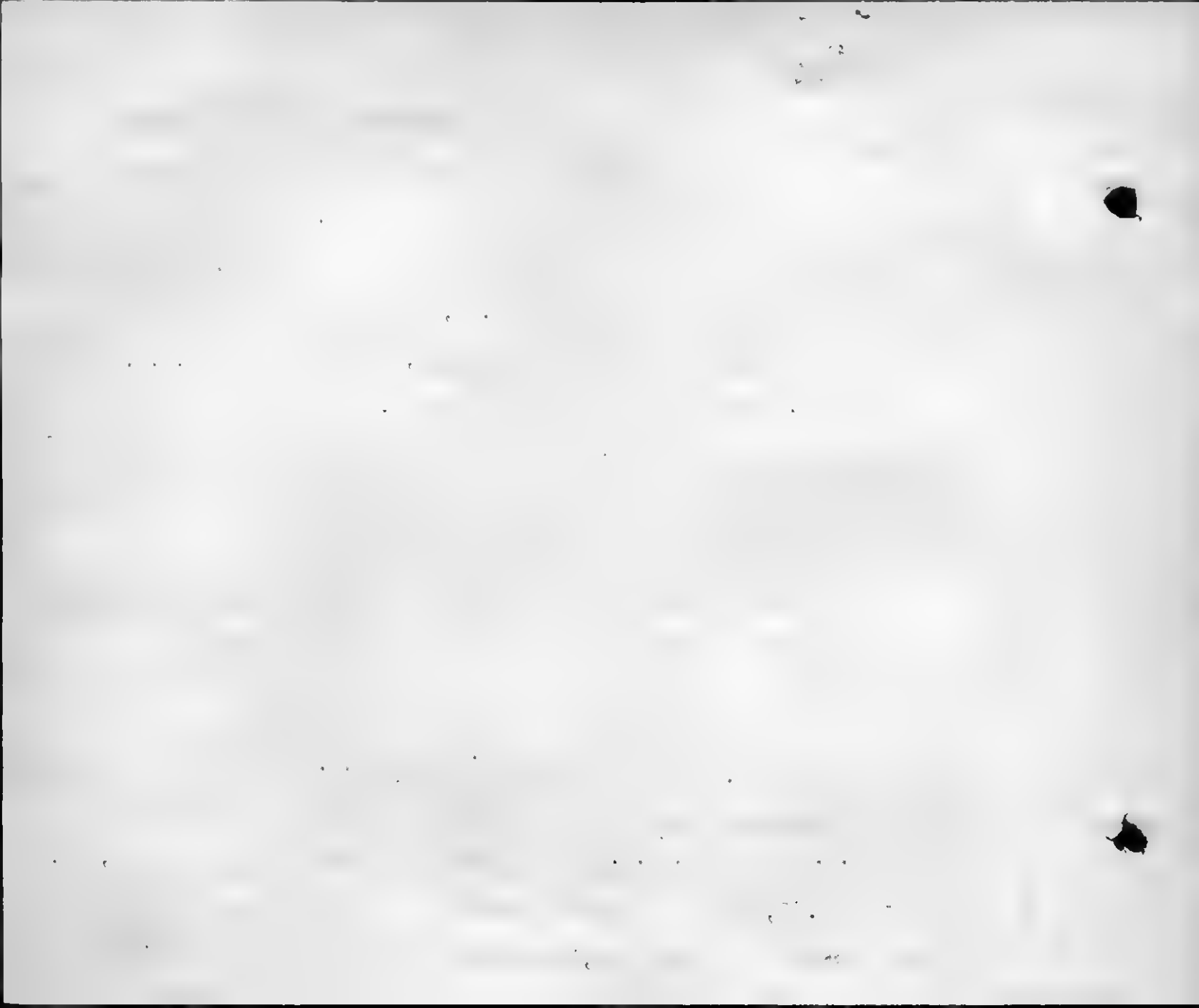
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if last tuition; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O. Al at Pen Gen Hospital</u>		d. STREET ADDRESS <u>325 Craft Street</u>	
3. NAME OF DECEASED (Type or print) <u>DONALD HENRY HAMPSHIRE</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>28</u> Year <u>1962</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 26, 1931</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lineman (Employee) Telephone Company</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Salisbury, Maryland</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Roscoe Hampshire</u>		14. MOTHER'S MAIDEN NAME <u>Gertrude Waller</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>YES - Korea -</u>		17. INFORMANT <u>Mrs. Saralene P. Hampshire (Wife)</u> <u>St. Salisbury, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>42</u> DUE TO (b) <u>Intense Pleuritic Heart Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>years</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
SIGNATURE <u>Dr. Earl L. Royer</u> EXAMINER'S NAME (Type) <u>407 Camden Ave. Salisbury, Md</u>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, c'ty, town, or county) <u>Jan. 30 / 1962</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 31, 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u>	22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u>
23. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u>		ADDRESS <u>SALISBURY, MARYLAND</u>	
24a. REC'D BY REG. STRAR <u>FEB 1 '62</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
01314
CERTIFICATE OF DEATH
01997

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
c. LENGTH OF STAY IN 1b since 12/26/61		d. STREET ADDRESS 207 Broad St.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) LOUDER CLAUDE HEARNE		4. DATE OF DEATH Jan. 27 1962	
5. SEX M		6. COLOR OR RACE W	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> Dec. 2, 1889		8. DATE OF BIRTH 72 yrs.	
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 2 Days 1	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Salesman		10b. KIND OF BUSINESS OR INDUSTRY Retail store	
11. BIRTHPLACE (County & State, or foreign country) Gumboro, Delaware		12. CITIZEN OF WHAT COUNTRY U.S.A.	
13. FATHER'S NAME Louder T. Hearne		14. MOTHER'S MAIDEN NAME Fannie H. Cannon	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Miss Elsie Hearne (Sister) 207 Broad St - City	
17. INFORMANT Records of Pine Bluff State Hospital		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) unknown DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Pulmonary tuberculosis	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/C		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/C	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Dec. 26, 1961 to Jan. 27, 1962 that (I) (we) last saw the deceased alive on Jan. 27, 1962 , and that death occurred at 1:58 p.m. from the causes and on the date stated above.			
22a. SIGNATURE E.P. Ritchings		22b. DATE SIGNED 1/27/62	
22c. PHYSICIAN'S NAME (Type) E.P. Ritchings, M.D.		22d. ADDRESS Pine Bluff Hospital, Salisbury, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 30, 1962	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town or county) (State) Salisbury, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR DATE FEB 1 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Kane			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be filled with the name of the funeral director, and the funeral director should be filled with the name of the funeral director.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01315

01298

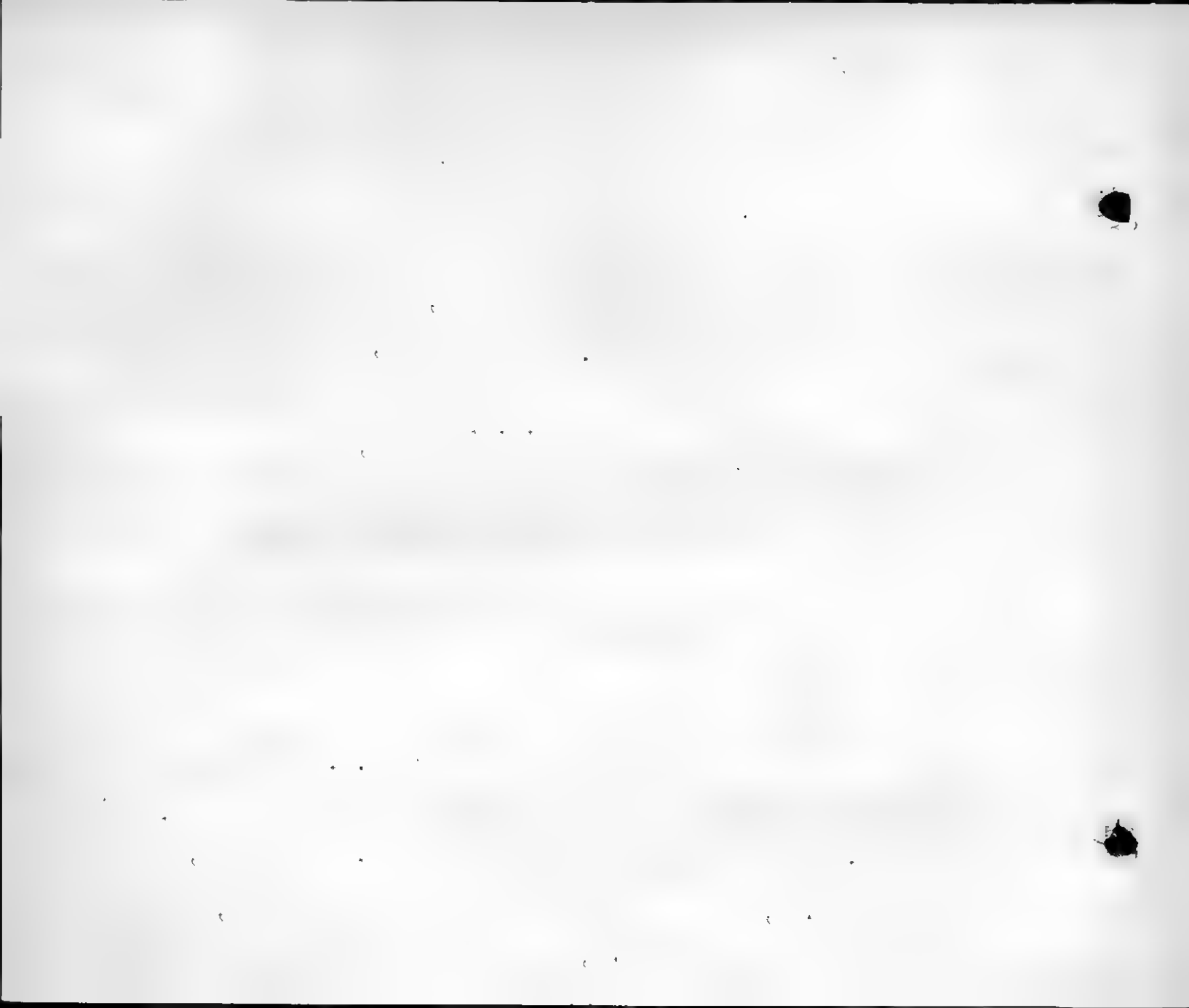
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First ODA Middle MAE Last HEATH		4. DATE OF DEATH Month JANUARY Day 19 Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 28, 1889
9. AGE (In years last birthday) 72 yrs.		10. IF UNDER 1 YEAR Months 72 Days 72 Hours 72 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired "Operator" Telephone Co.		10b. KIND OF BUSINESS OR INDUSTRY Salisbury, Maryland	
11. BIRTHPLACE (State or foreign country) Salisbury, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Albert Purnell Ellis		14. MOTHER'S MAIDEN NAME Rebecca Fleming	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO No	
17. INFORMANT Mrs. L. H. Howard (Daughter)		Address 842 West Main St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic heart disease gott DUE TO (c) malnutrition			INTERVAL BETWEEN ONSET AND DEATH minutes 6 yrs
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) malnutrition			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour o m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1951 to 1962 , that (I) (we) last saw the deceased alive on 1/19 19 62 and that death occurred at 10:15 A.M. from the causes and on the date stated above.			
22a. SIGNATURE Alberta Mattax		22b. DATE SIGNED Jan. 20/1962	
22c. PHYSICIAN'S NAME (Type) Dr. Alberta Mattax		22d. ADDRESS Camden Ave. Salisbury, Maryland	
23a. BURIAL, CREMATON, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 22, 1962	23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	23d. LOCATION (City, town, or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR JAN 22 '62		25b. REGISTRAR'S SIGNATURE W. H. & H. H. H.	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician, and completely filled in by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15M 9/

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01316

01299

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>Locus St. Hill</u>	
3. NAME OF DECEASED (Type or print) <u>Ruby</u> First Middle Last		DATE OF DEATH <u>JANUARY 3 1962</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 11, 1912</u>
9. AGE (In years last birthday) <u>49</u> yrs.		10. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William S. Williams</u>		14. MOTHER'S MAIDEN NAME <u>Ellen Purnell</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>12-26</u>	
17. INFORMANT <u>Ellen Purnell</u>		18. ADDRESS	
CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis Mid Cerebral Artery, Left</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Degenerative Cardiovascular Disease</u> DUE TO (a), stating the underlying cause last. (c) <u>Diabetes Mellitus</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12-26</u>, 19<u>61</u>, to <u>1-3</u>, 19<u>62</u>, that (I) (we) last saw the deceased alive on <u>11/3</u>, 19<u>62</u>, and that death occurred at <u>8:12 P.M.</u>, from the causes and on the date stated above.			
22a. SIGNATURE <u>George H. Henning</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Fruitland Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/7/1962</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Green acres</u>		23d. LOCATION (City, town or county) <u>Salisbury</u> (State) <u>Md</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Stewart</u>		25a. REC'D BY REGISTRAR <u>Arthur S. Stewart</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>JAN 15 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

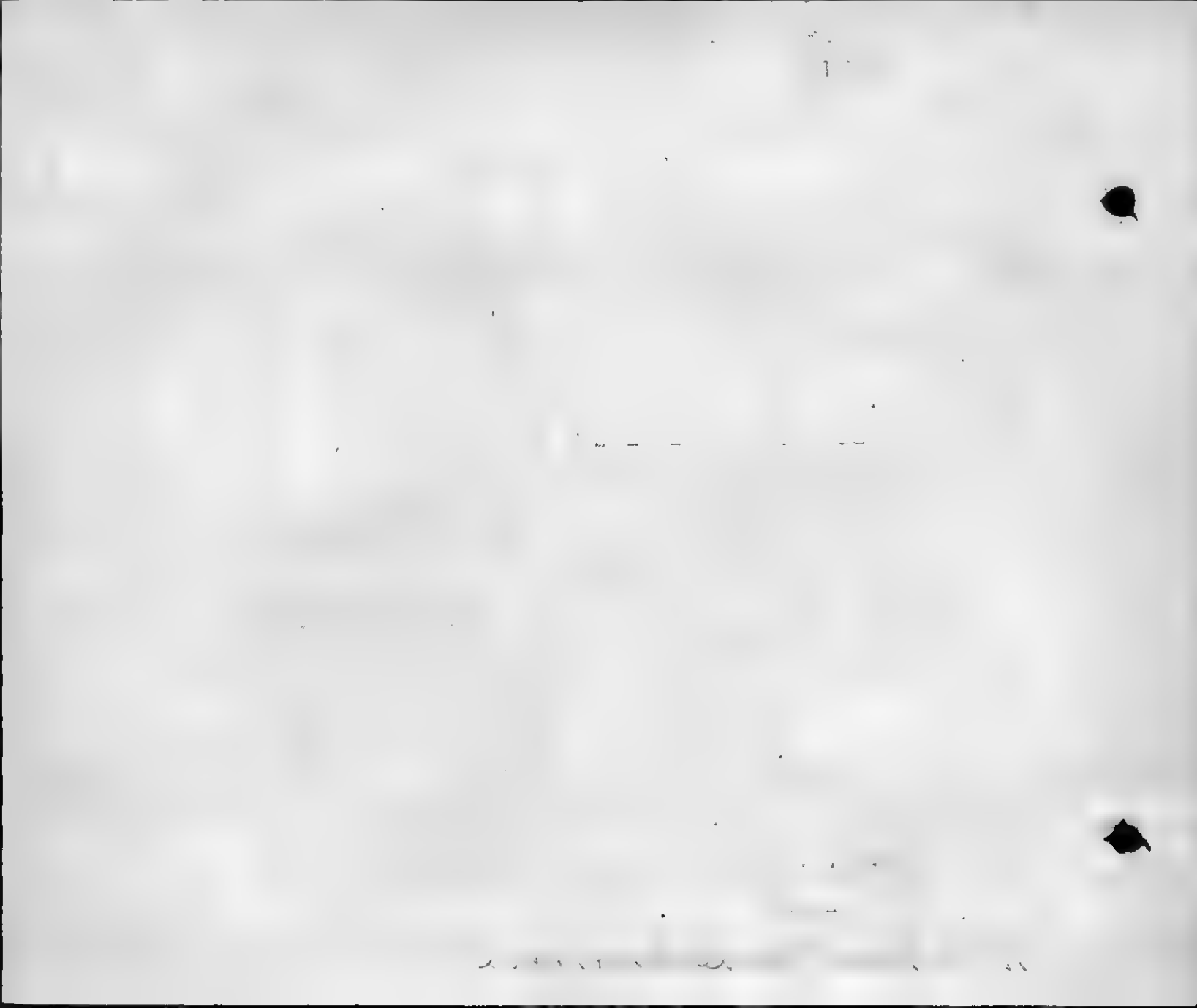
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01317

01317

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> c. LENGTH OF STAY IN 1b <u>77 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>406 Pine Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> d. STREET ADDRESS <u>406 Pine Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>EDWARD</u> Middle <u>LEVIN</u> Last <u>HITCHENS</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>11th</u> Year <u>1962</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Jan. 23, 1884</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		10. IF UNDER 1 YEAR Months <u>7</u> Days <u>11</u>	
11. IF UNDER 24 HRS. Hours <u>11</u> Min. <u>00</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Trainman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Delmar, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>James B. Hitchens</u>		14. MOTHER'S MAIDEN NAME <u>Ella Arvey</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give year or dates of service)		16. SOCIAL SECURITY NO. <u>716-03-1584</u>	
17. INFORMANT <u>Cora Hitchens, Delmar, Maryland</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> DUE TO (b) <u>Coronary arteriosclerosis</u> DUE TO (c) <u>Arteriosclerosis generalized - Arteriosclerotic heart dis.</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. INTERVAL BETWEEN ONSET AND DEATH <u>2 min 6 years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>10</u> a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 1961</u> to <u>Jan 11th 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 11th 1962</u> and that death occurred at <u>10:00</u> P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>L. V. Sohler</u>		22b. DATE SIGNED <u>1-12-62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. L. V. Sohler</u>		22d. ADDRESS <u>Delmar, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-14-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olive</u>		23d. LOCATION (City, town or county) (State) <u>Delmar, Delaware</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Marvel Co - Delmar, Del</u>		25a. REC'D BY REGISTRAR <u>JAN 16 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

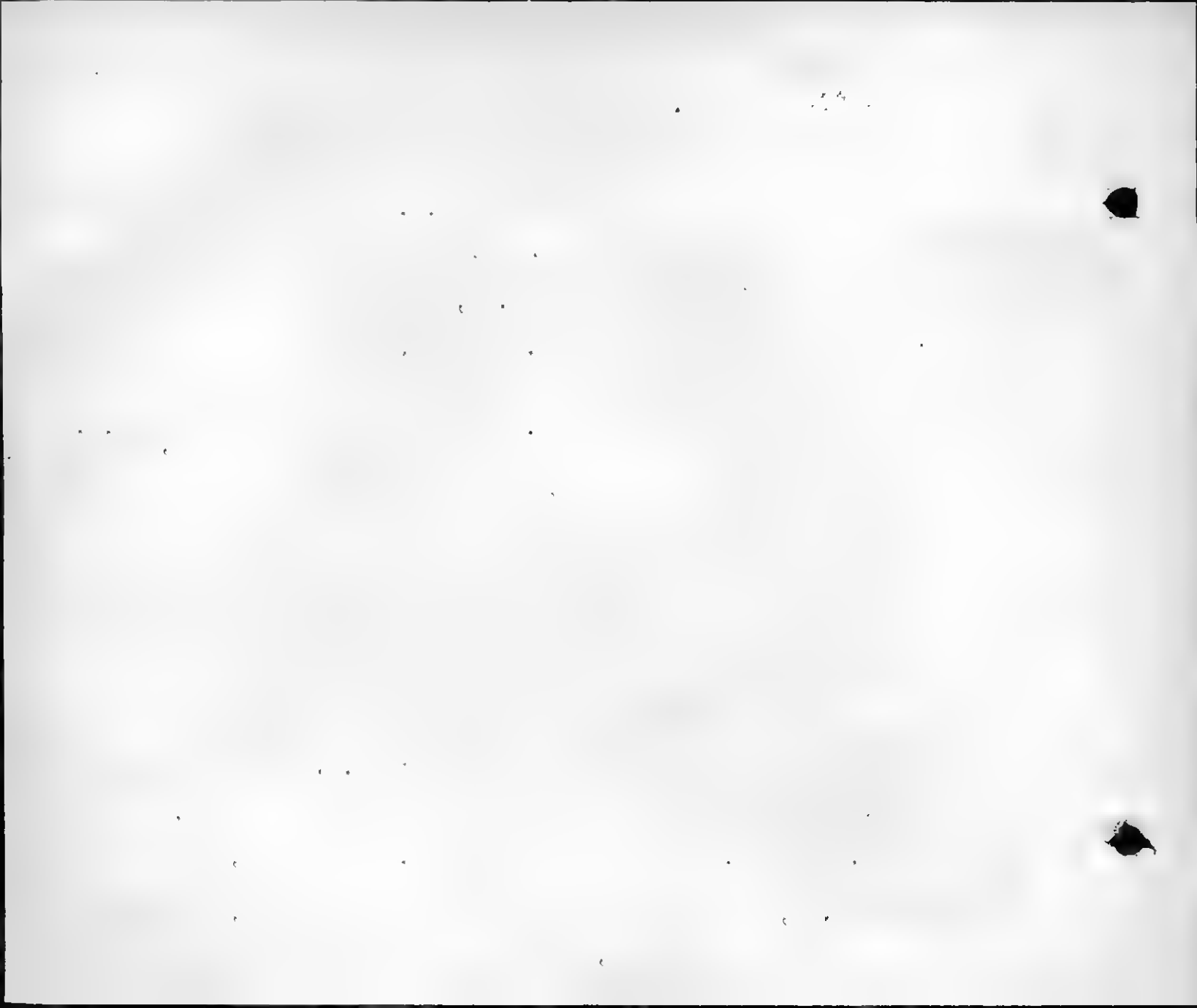
01318

01361

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital				d. STREET ADDRESS R.D.# 5 (Crooked Oak Lane)		e. IS RESIDENCE ON A FARM? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
3. NAME OF DECEASED (Type or print) First ANDREW Middle JACKSON Last HOPKINS				4. DATE OF DEATH Month JANUARY Day 22nd Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dec. 22, 1900	
9. AGE (In years last birthday) 61 yrs		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee (Supply Clerk) Trucking Co.		11. BIRTHPLACE (State or foreign country) Tyaskin, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Dashiell Hopkins				14. MOTHER'S MAIDEN NAME Minnie Riell			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO. INFORMANT Mrs. Bernice Bailey Hopkins (Wife) R.D.# 5 Crooked Oak Lane Salisbury, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: 527.1 IMMEDIATE CAUSE (a) acute pulmonary angina DUE TO Ch. Emphysema Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A			
20c. TIME OF INJURY Month, Day, Year Hour o. m. N/A 19 19 p. m. N/A				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A	
20f. (City or town) N/A				20g. (County) N/A			
20h. (State) N/A				20i. (City or town) N/A			
21. I certify that (I) (this hospital) attended the deceased from 1-17-1962 to 1-22-1962 , that (I) (we) last saw the deceased alive on 1-21-1962 , and that death occurred at 12:00 A.M. from the causes and on the date stated above.							
22a. SIGNATURE Philip A. Insley				22b. DATE Jan. 23 / 1962			
22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley				22d. ADDRESS Main St. Salisbury, Maryland			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial				23b. DATE THEREOF Jan. 24, 1962		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	
23d. LOCATION (City, town, or county) Salisbury, Maryland				23e. (State) Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY				25a. REC'D BY REGISTRAR JAN 26 '62		25b. REGISTRAR'S SIGNATURE Robert S. K...	

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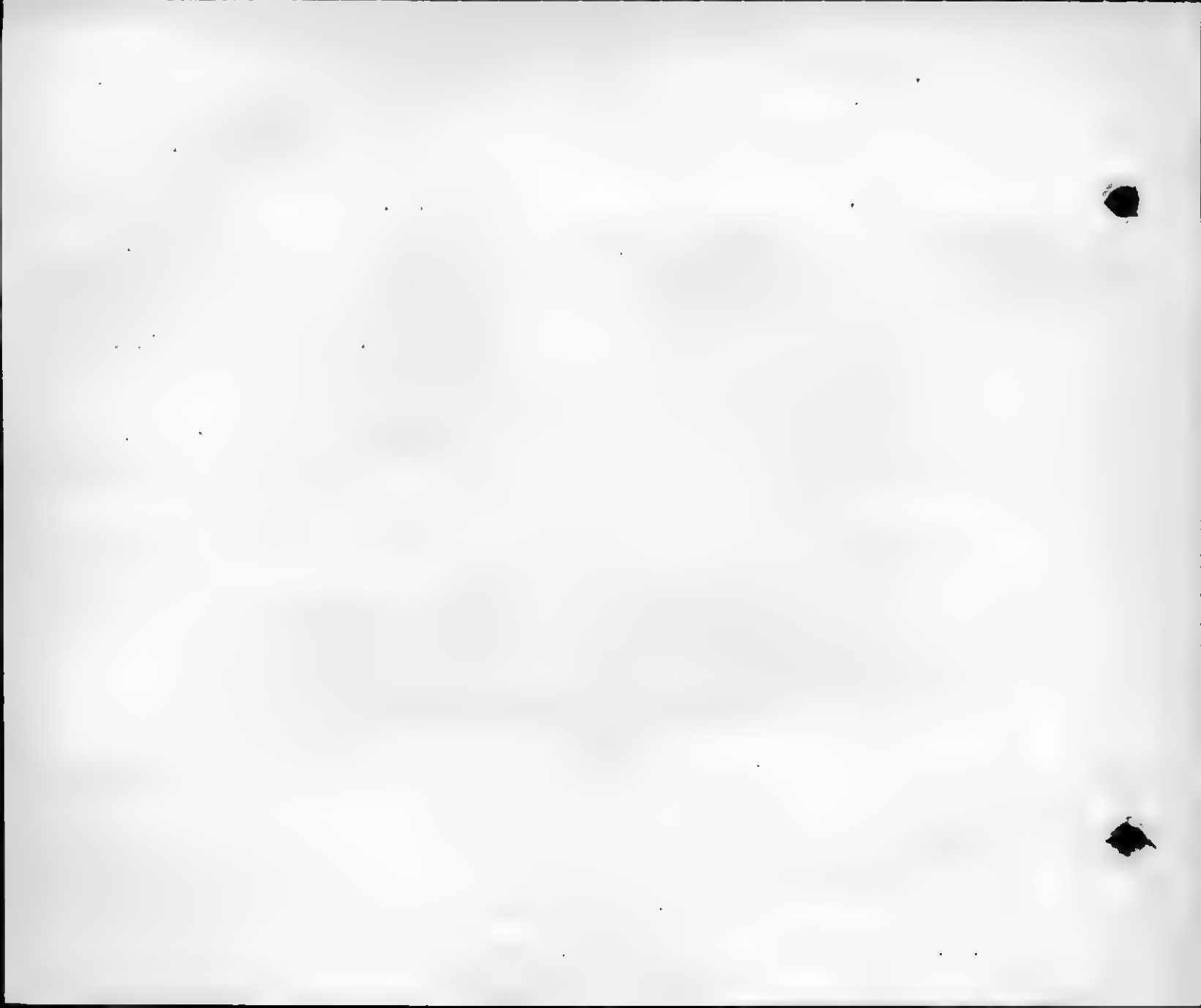
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01319

01342

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND				2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs - Rural				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION San Domingo				e. STREET ADDRESS 1 R. F. D.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Florence Middle Irene Last Hopkins				4. DATE OF DEATH Month January Day 18 Year 19 62			
5. SEX Female	6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 10, 1909	9. AGE (In years last birthday) 52 yrs	IF UNDER 1 YEAR Months 52 Days 0 Hours 0 Min. 0	IF UNDER 24 HRS. Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework		10b. KIND OF BUSINESS OR INDUSTRY Home		11. BIRTHPLACE (State or foreign country) Wicomico Co., Maryland		12. CITIZEN OF WHAT COUNTRY? R.F.D.	
13. FATHER'S NAME Edward Fooks				14. MOTHER'S MAIDEN NAME Jeanette Johns			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) NO (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 213-14-6817		17. INFORMANT Otis L. Hopkins, Mardela Springs, Md., RFD			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral Vascular Accident 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Dis DUE TO unknown (c) Nephritis DUE TO unknown						INTERVAL BETWEEN ONSET AND DEATH -	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 6 Jan. 1962 to 18 Jan. 1962 that (I) (yes) last saw the deceased alive on 18 Jan. 1962 and that death occurred at 3:15 AM from the causes and on the date stated above.							
22a. SIGNATURE G. G. Schlesinger M.D.				ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22b. DATE SIGNED 19 Jan 62	
22c. PHYSICIAN'S NAME (Type) George G. Schlesinger				22d. ADDRESS Box 151 Mardela, Maryland			
23a. BURIAL, CREMATION REMOVAL (Specify) Burial		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery		23d. LOCATION (City, town, or county) (State) Near Sharptown, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE J. J. Framptom and Son, Federalsburg, Maryland				25a. REC'D BY REGISTRAR DATE JAN 24 '62		25b. REGISTRAR'S SIGNATURE C. L. Moore	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed with page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

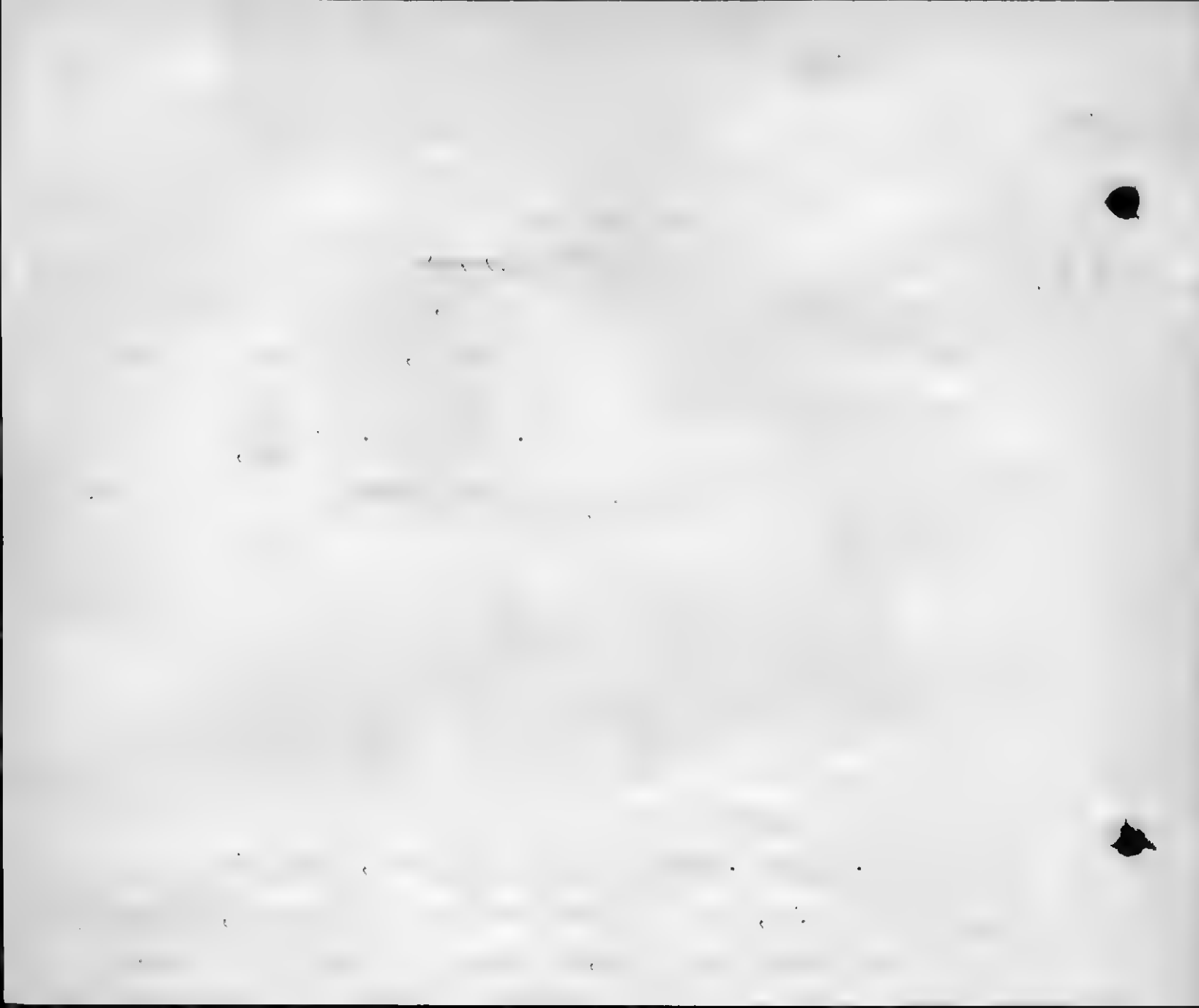
01320

01393

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> d. STREET ADDRESS <u>818 Smith Street</u>	
3. NAME OF DECEASED (Type or print) <u>CARLTON</u> e. SEX <u>MALE</u> f. COLOR OR RACE <u>White</u> g. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> h. DATE OF BIRTH <u>March 5, 1904</u> i. WIDOWED <input type="checkbox"/> j. DIVORCED <input type="checkbox"/>		4. DATE OF DEATH <u>JANUARY 19 1962</u> k. AGE (In years last birthday) <u>57</u> yrs. l. IF UNDER 1 YEAR <u>10</u> Months <u>14</u> Days <u>1</u> Hour <u>15</u> Min. m. IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Service Station Attendant</u> 10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Bivalve, Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>George Horsman</u>		14. MOTHER'S MAIDEN NAME <u>Eunice Wilson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give year or dates of service)		16. SOCIAL SECURITY NO. <u>1</u> 17. INFORMANT <u>Mrs. Florence B. Horsman (Wife)</u> <u>818 Smith Street Salisbury, Maryland</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>420.1</u> DUE TO <u>Coronary Thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>N/A</u> 20c. TIME OF INJURY Hour a.m. <u>19</u> p.m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JULY 1961</u> to <u>JAN 19, 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 19 1962</u> and that death occurred at <u>2:08 PM</u> from the causes and on the date stated above. 22a. SIGNATURE <u>Dr. Robert T. Adkins</u> 22b. DATE SIGNED <u>19 JAN 62</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Robert T. Adkins</u> 22d. ADDRESS <u>Fruitland, Maryland</u> 22e. MED. DIRECTOR <input checked="" type="checkbox"/> 22f. STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, 23b. DATE THEREOF <u>Burial Jan. 21, 1962</u> REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> 25a. REC'D BY REGISTRAR <u>JAN 22 '62</u> 25b. REGISTRAR'S SIGNATURE		25c. DATE <u>JAN 22 '62</u>	

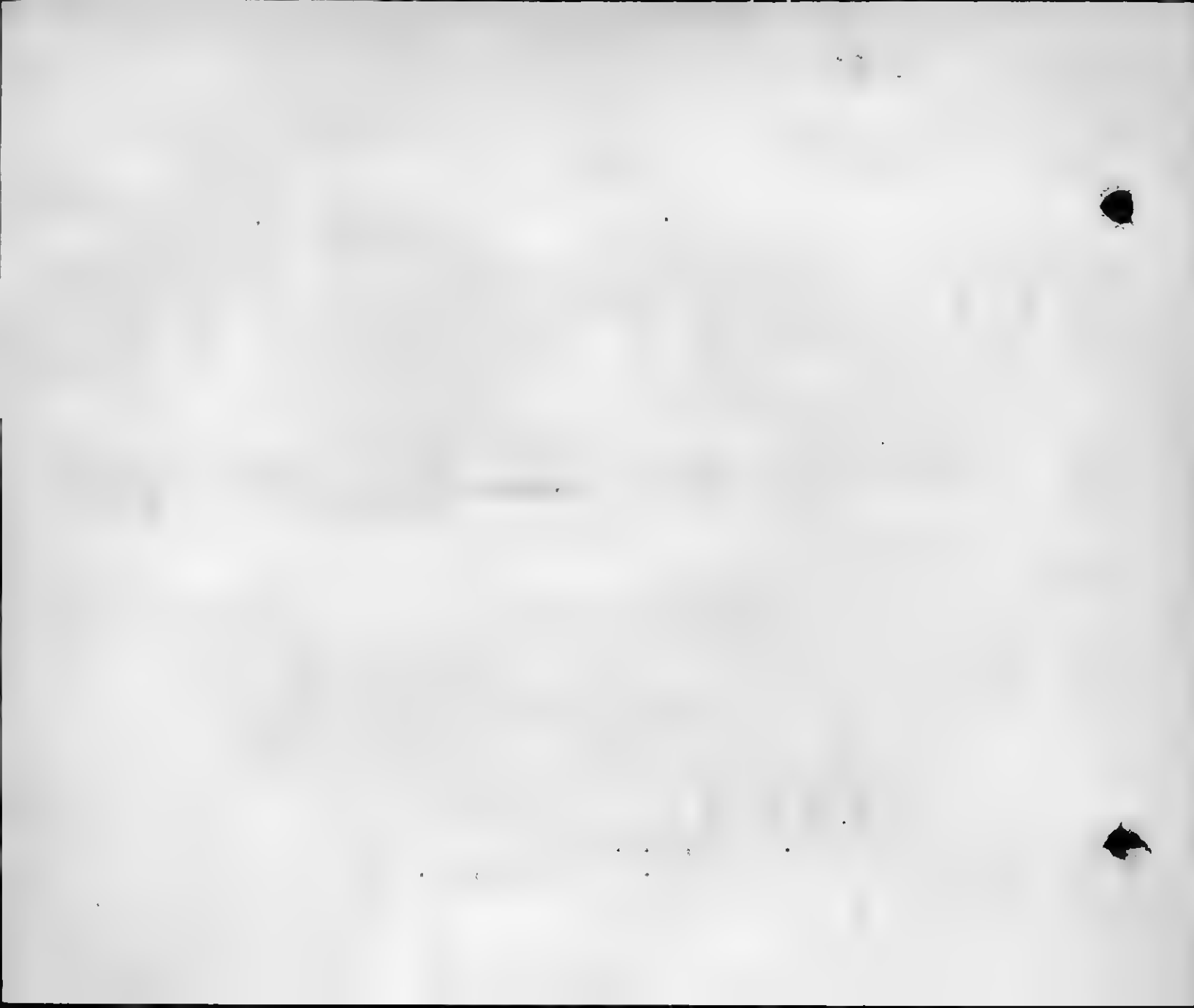
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
01321 MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>				2. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. LENGTH OF STAY IN 1b <u>4 yrs</u>				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>111 Catherine St.</u>				d. STREET ADDRESS <u>111 Catherine St.</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Harvey</u>				4. DATE OF DEATH <u>1-13-62</u>				5. SEX <u>M</u>			
6. COLOR OR RACE <u>AA</u>				7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				8. DATE OF BIRTH <u>June 12 1900</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>				9. AGE (In years last birthday) <u>61</u> yrs.			
13. FATHER'S NAME <u>Charles Hughes</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Parker</u>				11. BIRTHPLACE (State or foreign country) <u>these Island</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>				16. SOCIAL SECURITY NO. <u>?</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>331X</u> DUE TO <u>Cerebral Hemorrhage Spontaneous</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I, (a) INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>											
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) <u>Salisbury</u>				20g. (County) <u>Wicomico</u>				20h. (State) <u>Md</u>			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Earl L. Royer</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED <u>1-15-62</u>			
EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u>				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>1-16-62</u>				22c. NAME OF CEMETERY OR CREMATORY <u>these Island Cem</u>			
22d. LOCATION (City, town, or country) <u>these Island</u>				22e. (State) <u>Md</u>				23. FUNERAL DIRECTOR <u>Booker McWent</u>			
24a. REC'D BY REGISTRAR <u>DATE JAN 22 '62</u>				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law also requires that the death certificate be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

<div style="text-align: center;"> MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH </div>										
1. PLACE OF DEATH a. COUNTY <u>Wicomico County</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN <u>195 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset County</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> d. STREET ADDRESS <u>Box 205, Route 2</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>Samuel James HUTT</u>					4. DATE OF DEATH Month <u>January</u> Day <u>25</u> Year <u>1962</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1/10/1</u>		9. AGE (In years last birthday) <u>51 yrs.</u> IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS. Hours <u>0</u> Min. <u>0</u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Labor</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Form</u>			11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A.</u>		
13. FATHER'S NAME <u>George Hutt</u>					14. MOTHER'S MAIDEN NAME <u>Mary ?</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>			16. SOCIAL SECURITY NO. <u>214-12-6616</u>		17. INFORMANT <u>Annie Mae Hutt, Princess Anne, Md</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> (b) <u>Arteriosclerotic cardiovascular disease</u> (c) <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>2-3 years</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>9</u> a.m. p.m. <u>19</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 13, 1961</u> to <u>Jan. 25, 1962</u>, that (I) (we) last saw the deceased alive on <u>Jan. 25, 1962</u>, and that death occurred at <u>9:40 A.M.</u> from the causes and on the date stated above.										
22a. SIGNATURE <u>V. Juerman</u>					22b. DATE SIGNED <u>1/25/62</u>		22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>			
22d. ADDRESS <u>Deer's Head State Hospital</u> <u>Salisbury, Md.</u>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Interment</u>			23b. DATE THEREOF <u>1/23/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's</u>		23d. LOCATION (City, town or county) <u>Nest Post Office, Md</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Walter A. J. Juerman</u>					25a. REC'D BY REGISTRAR <u>DATE JAN 31 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur L. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Payment may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filled with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

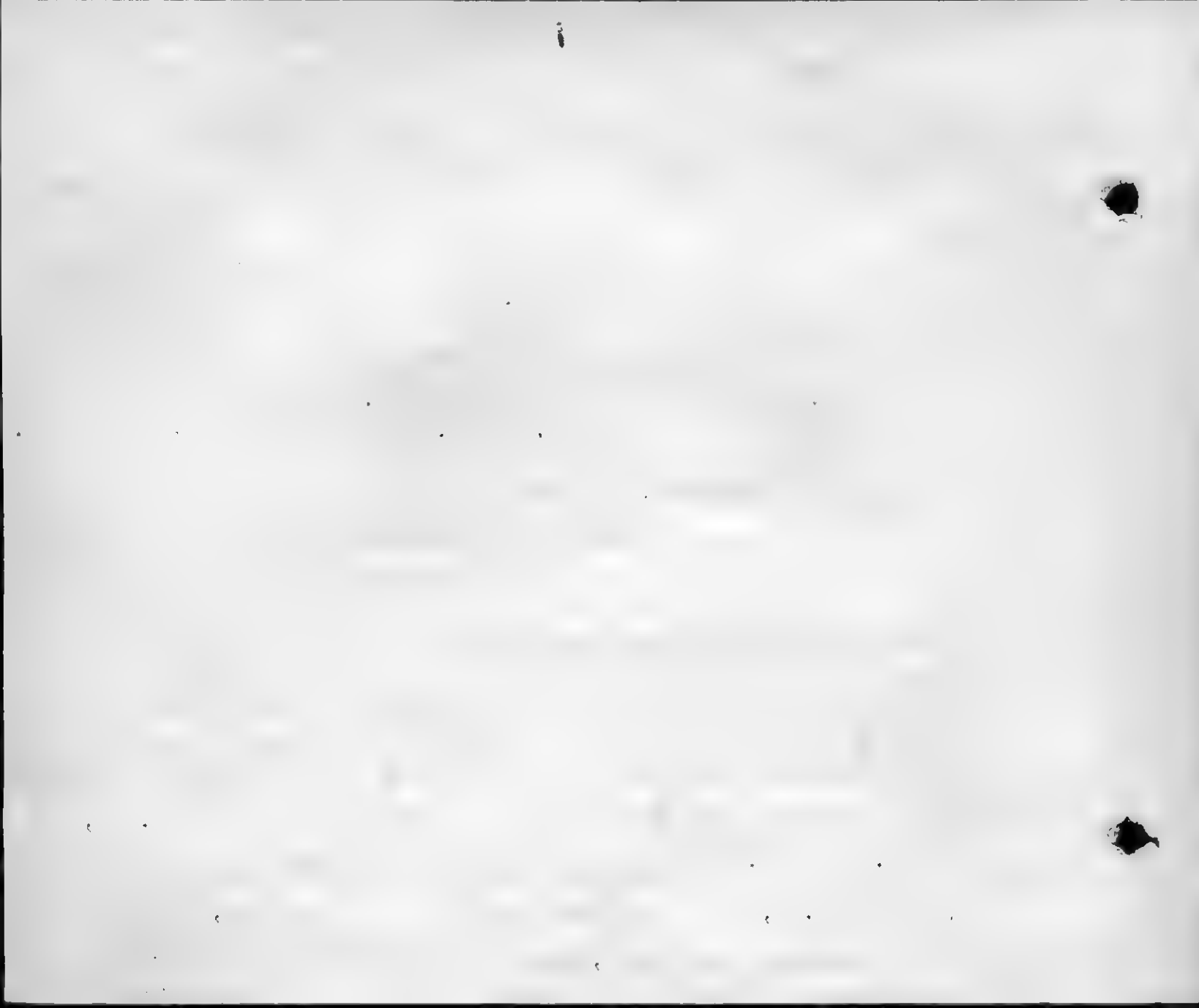
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01323

01306

1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN lb Since 12/4/61 d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Pine Bluff State Hospital		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs d. STREET ADDRESS -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Guy Middle Franklin Last Jackson		4. DATE OF DEATH Month Jan. Day 18 Year 19 62		5. SEX Male 6. COLOR OR RACE White 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Railroad Agent		10b. KIND OF BUSINESS OR INDUSTRY Railroad		11. BIRTHPLACE (County & State, or foreign country) Wicomico, Maryland	
13. FATHER'S NAME Clayton G. Jackson		14. MOTHER'S MAIDEN NAME Dora E. Oliphant		12. CITIZEN OF WHAT COUNTRY? USA	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 717-07-9572		17. INFORMANT Address Mrs. Edna E. Jackson (Wife) Box #8-Mardela, Md. Records of Pine Bluff State Hospital	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) Metastatic Cancer 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cancer of the lung [Bronchiogenic Carcinoma] 2 years? DUE TO (c) squamous cell		INTERVAL BETWEEN ONSET AND DEATH		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE. CONDITION GIVEN IN PART I (a) Modestly advanced, active Tbc		20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of Item 18.] 005.1	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 005.1	
20f. (City or town) Salisbury		20g. (County) Wicomico		20h. (State) Md.	
21. I certify that (this hospital) attended the deceased from 11 Nov. 1961 to 18 Jan. 1962 , that (I) (we) last saw the deceased alive on 18 Jan. 1962 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.					
22a. SIGNATURE Joseph C. Fitzgerald, MD. M.D. 22c. PHYSICIAN'S NAME (Type) Dr. Joseph C. Fitzgerald		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22d. ADDRESS Pine Bluff Road, Salisbury		22b. DATE SIGNED Jan. 18, 1962	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 21, 1962		23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery	
23d. LOCATION (City, town or county) Salisbury, Maryland		23e. (State) Md.		23f. (Country) USA	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR JAN 22 '62	
25b. REGISTRAR'S SIGNATURE Arthur S. Knease		25c. (City, town or county) Salisbury		25d. (State) Md.	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

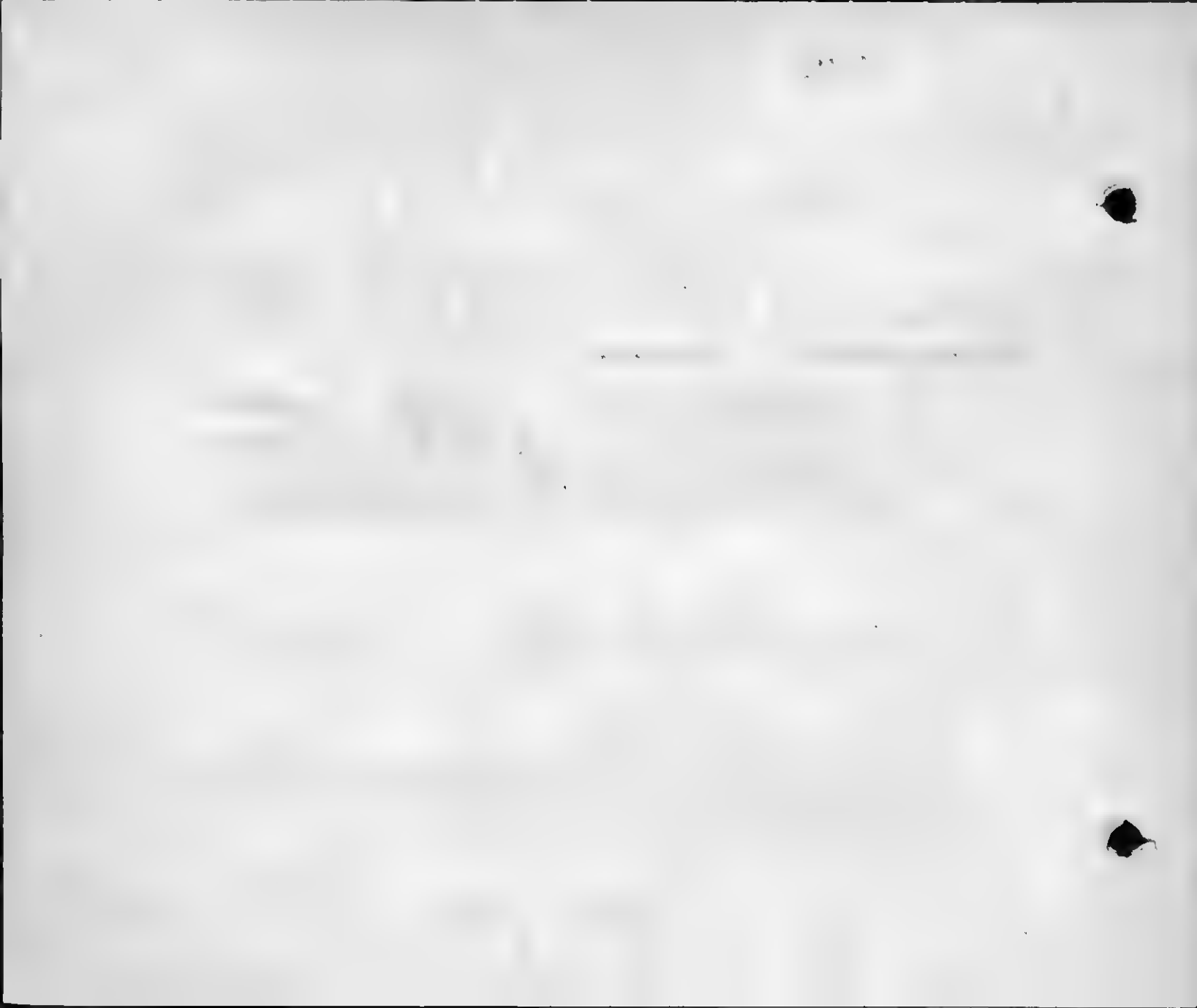
CERTIFICATE OF DEATH

01324

01307

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Worcester</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> d. STREET ADDRESS <u>424 Bank Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William Albert Jones</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>16</u> Year <u>1962</u>	
5. SEX <u>male</u>		6. COLOR OR RACE <u>Colored</u>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>March 29 1902</u>	
9. AGE (In years last birthday) <u>59</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crossing Watchman Railroad</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Jones</u>		14. MOTHER'S MAIDEN NAME <u>Alice Washields</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>James Jones - Pocomoke, Md.</u>	
17. INFORMANT <u>James Jones - Pocomoke, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO <u>321X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO <u> </u> (c) <u> </u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Arteriosclerotic Heart Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/13</u> , 19 <u>62</u> , to <u>1/16</u> , 19 <u>62</u> , that (I) (we) last saw the deceased alive on <u>1/16</u> , 19 <u>62</u> , and that death occurred at <u>8:03</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>David J. Lohman</u>		22b. DATE SIGNED <u>1/16/62</u>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Salisbury Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-20-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cottage Grove</u>		23d. LOCATION (City, town or county) (State) <u>Westover, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>JAN 19 '62</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician and completed by the attending physician and completed by the attending physician. After this certificate has been signed by the attending physician and completed by the attending physician, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

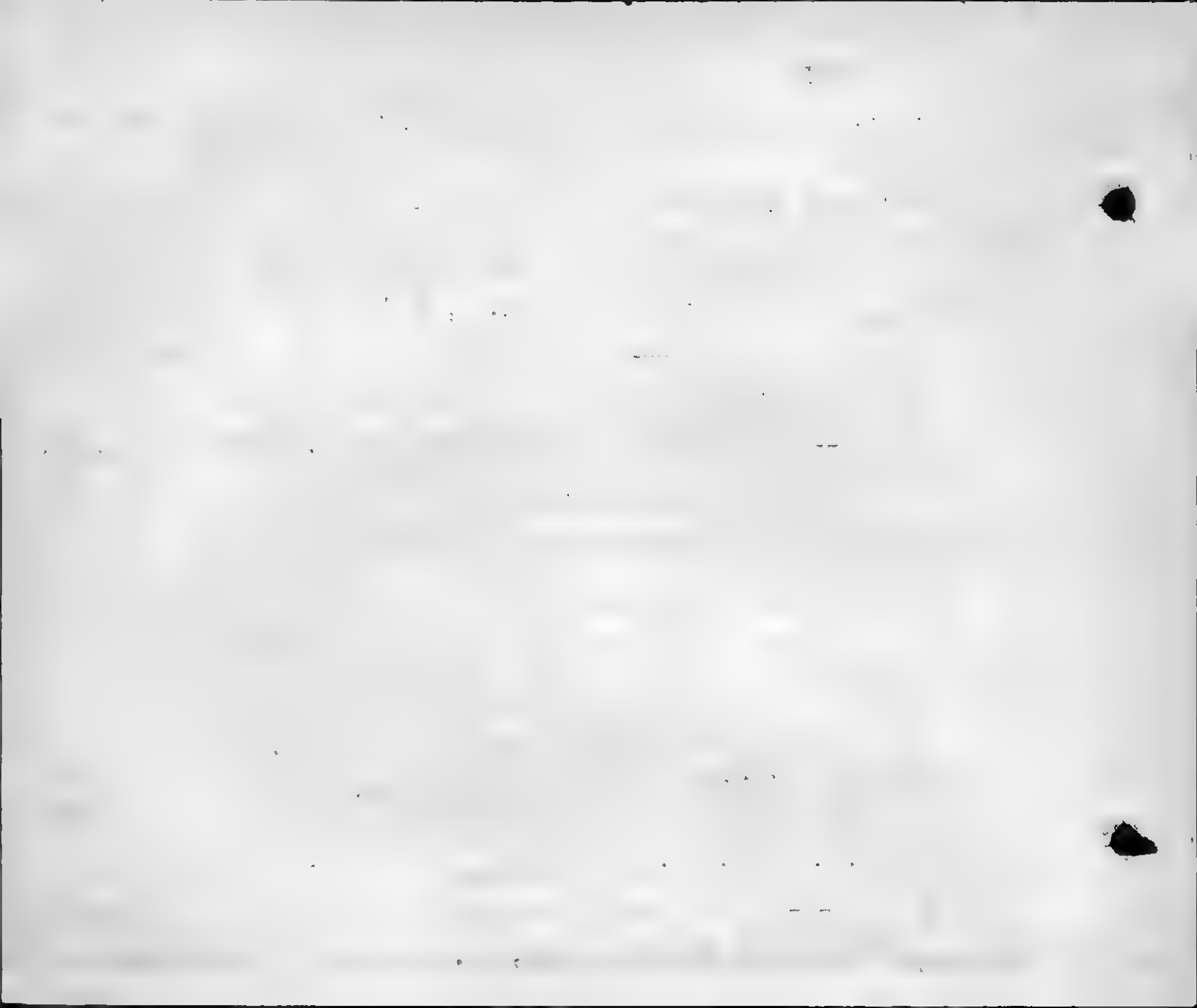
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01325

01308

1. PLACE OF DEATH a. COUNTY Wicomico County		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 3280 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Worcester County		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pocomoke City		d. STREET ADDRESS - - - -		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) Mary		First Ethel		Middle KELLY		Last KELLY		4. DATE OF DEATH Month January		Day 3,		Year 19 62					
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 3, 1884		9. AGE (In years last birthday) 77 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY ---		11. BIRTHPLACE (County & State, or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? USA											
13. FATHER'S NAME John Covington Parks		14. MOTHER'S MAIDEN NAME Jeanette Franklin Taylor															
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO None		17. INFORMANT Mrs Emma Wilkinson, Pocomoke City, Md.		Address											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) Arteriosclerotic heart disease (c) DUE TO (e), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)												INTERVAL BETWEEN ONSET AND DEATH 72 hours Years					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) 1/10 1961, to Jan. 3, 1962											
21. I certify that (I) (this hospital) attended the deceased from 1/10 1961, to Jan. 3, 1962 , that (I) (we) last saw the deceased alive on Jan. 3, 1962 , and that death occurred at 4:30 P.M. , from the causes and on the date stated above.																	
22a. SIGNATURE <i>L. V. Maldve</i>		22b. DATE SIGNED 1/4/62		22c. PHYSICIAN'S NAME (Type) L. V. Maldve, M.D.		22d. ADDRESS Deer's Head State Hospital Salisbury, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-5-62		23c. NAME OF CEMETERY Liberty Cemetery		23d. LOCATION (City, town or county) (State) Parksley, Virginia											
24. FUNERAL DIRECTOR'S SIGNATURE <i>Henry H. Watson</i>		ADDRESS Pocomoke City, Md.		25a. REC'D BY REGISTRAR JAN 8 '62		25b. REGISTRAR'S SIGNATURE <i>William S. Thomas</i>											

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND									
01326 Item 9 Film 0305 1/18/62 01300									
CERTIFICATE OF DEATH									
1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b 21 days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Wicomico	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Peninsula General Hospital						c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Fruitland		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) Mary Frances King		4. DATE OF DEATH January 4 1962		5. SEX Female		6. COLOR OR RACE Colored		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 3-10-10 51		9. AGE (In years last birthday) 10 yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Homemaker		10b. KIND OF BUSINESS OR INDUSTRY None		11. BIRTHPLACE (County & State or foreign country) Shutlond Md	
12. CITIZEN OF WHAT COUNTRY? U.S.		13. FATHER'S NAME Samuel Wilson		14. MOTHER'S MAIDEN NAME Mary Fountain		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) No		16. SOCIAL SECURITY NO. ?	
17. INFORMANT Henry Fountain		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Recurrent cerebral thrombosis DUE TO (b) 332 Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) Diabetes mellitus PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) Diabetes mellitus		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH 3 weeks			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <input type="checkbox"/>		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Dec. 11, 1961, to Jan. 4, 1962	
20f. (City or town) Salisbury		20g. (County) Wicomico		20h. (State) Md		21. I certify that (I) (this hospital) attended the deceased from Dec. 11, 1961, to Jan. 4, 1962 , that (I) (we) last saw the deceased alive on January 4, 1962 , and that death occurred at 11:10 P.M. from the causes and on the date stated above.		22a. SIGNATURE V. Juerman	
22b. DATE SIGNED 1/5/62		22c. PHYSICIAN'S NAME (Type) V. Juerman, M. D.		22d. ADDRESS Deer's Head Hospital; Salisbury, Md.		23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-9-62	
23c. NAME OF CEMETERY OR CREMATORY mt Calvary Cem Fruitland Md		23d. LOCATION (City, town or county) Fruitland Md		23e. (State) Md		24. FUNERAL DIRECTOR'S SIGNATURE Booker M. West		24a. ADDRESS 1-9-62	
25a. REC'D BY REGISTRAR JAN 11 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Francis		25c. DATE JAN 11 '62		25d. REGISTRAR'S SIGNATURE Arthur S. Francis		25e. DATE JAN 11 '62	

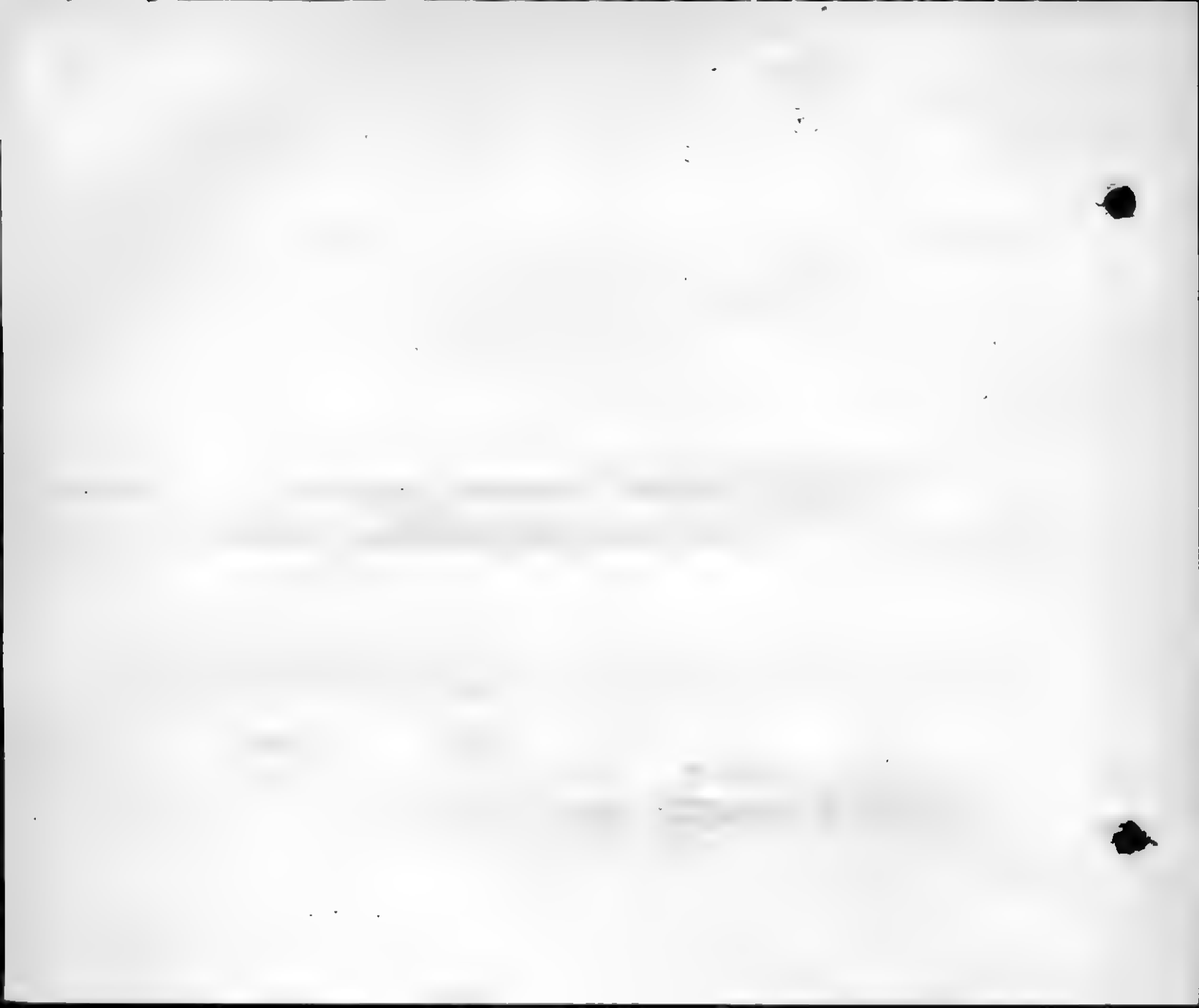


MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01327

01310

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural - Quantico</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Quantico</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>Emma J. Larkmore</u>				4. DATE OF DEATH Month <u>1</u> Day <u>28</u> Year <u>1952</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/21/1876</u>	9. AGE (In years and birthday) yrs. <u>75</u>	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Cann Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>William T. Johnson</u>				14. MOTHER'S MAIDEN NAME <u>Lezlie Moore</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT Address <u>Cora Horner, Quantico, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Congestion failure</u> DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>10 yr</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <u>4-22-1</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>minutes</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1/18/62</u> to <u>1/28/62</u> , that (I) (we) last saw the deceased alive on <u>1/28/62</u> , and that death occurred at <u>11/30/62</u> M, from the causes and on the date stated above							
22a. SIGNATURE <u>Alberta Mattox MD</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>1/30/62</u>	
22c. PHYSICIAN'S NAME (Type)				22d. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/31/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Birchview Cem.</u>		23d. LOCATION (City, town, or county) (State) <u>Birdsboro, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>11/20/62 Birchview, Md.</u>				25a. REC'D BY REGISTRAR <u>FEB 1 1962</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>	



may be reviewed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

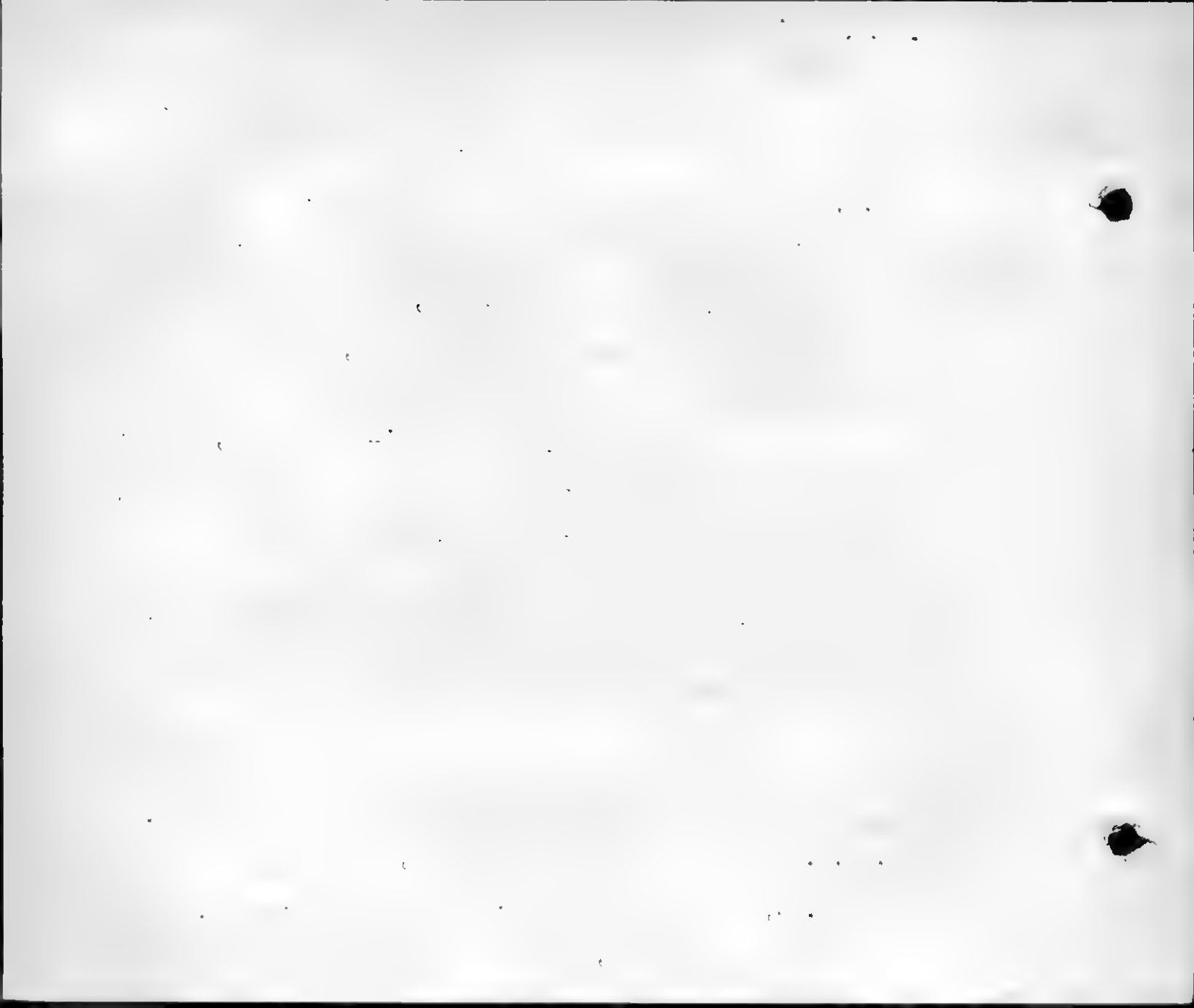
01328

01311

01328

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION XXX, Box # 20 Cherryway		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle HANDY Last LITTLETON		4. DATE OF DEATH Month JANUARY Day 15 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH August 1, 1879
9. AGE (In years last birthday) 82 yrs		10. IF UNDER 1 YEAR Months 5 Days 14 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY None	
11. BIRTHPLACE (State or foreign country) Whayleville, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME John Wesley Littleton		14. MOTHER'S MAIDEN NAME Ellen Cooper	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs Bessie K. Jones (Daughter) 70 Cherry way- Salisbury, Maryland		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.1 DUE TO Coronary artery occlusion Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary arteriosclerosis DUE TO (c) 		INTERVAL BETWEEN ONSET AND DEATH 2 min	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerosis, generalized and cerebral. Hemiplegia.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 15 19 62 , to Jan 15 19 62 , that (I) (we) last saw the deceased alive on Jan 20 19 62 , and that death occurred at 12:56 M, from the causes and on the date stated above.			
22a. SIGNATURE L.V. Sohler		22b. DATE SIGNED Jan. 1962	
22c. PHYSICIAN'S NAME (Type) Dr. L.V. Sohler		22d. ADDRESS Delmar, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 18, 1962	23c. NAME OF CEMETERY OR CREMATORY Rehobeth Cemetery	23d. LOCATION (City, town, or county) (State) Worcester Co. Maryland
24. FUNERAL DIRECTOR'S SIGNATURE HOLLICWAY & COMPANY		25a. REC'D BY REGISTRAR JAN 22 1962	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur S. Knecht	



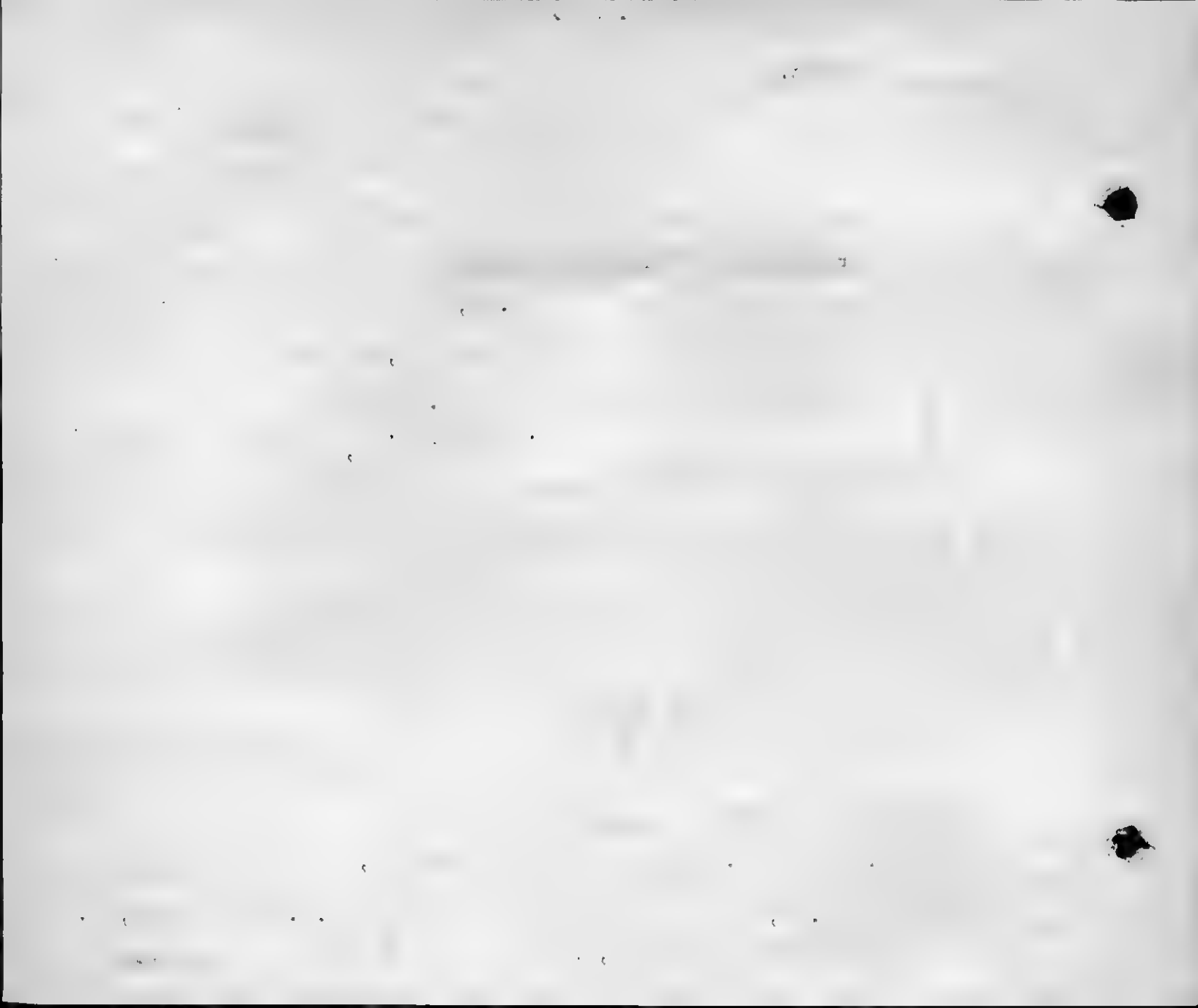
TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01329

01312

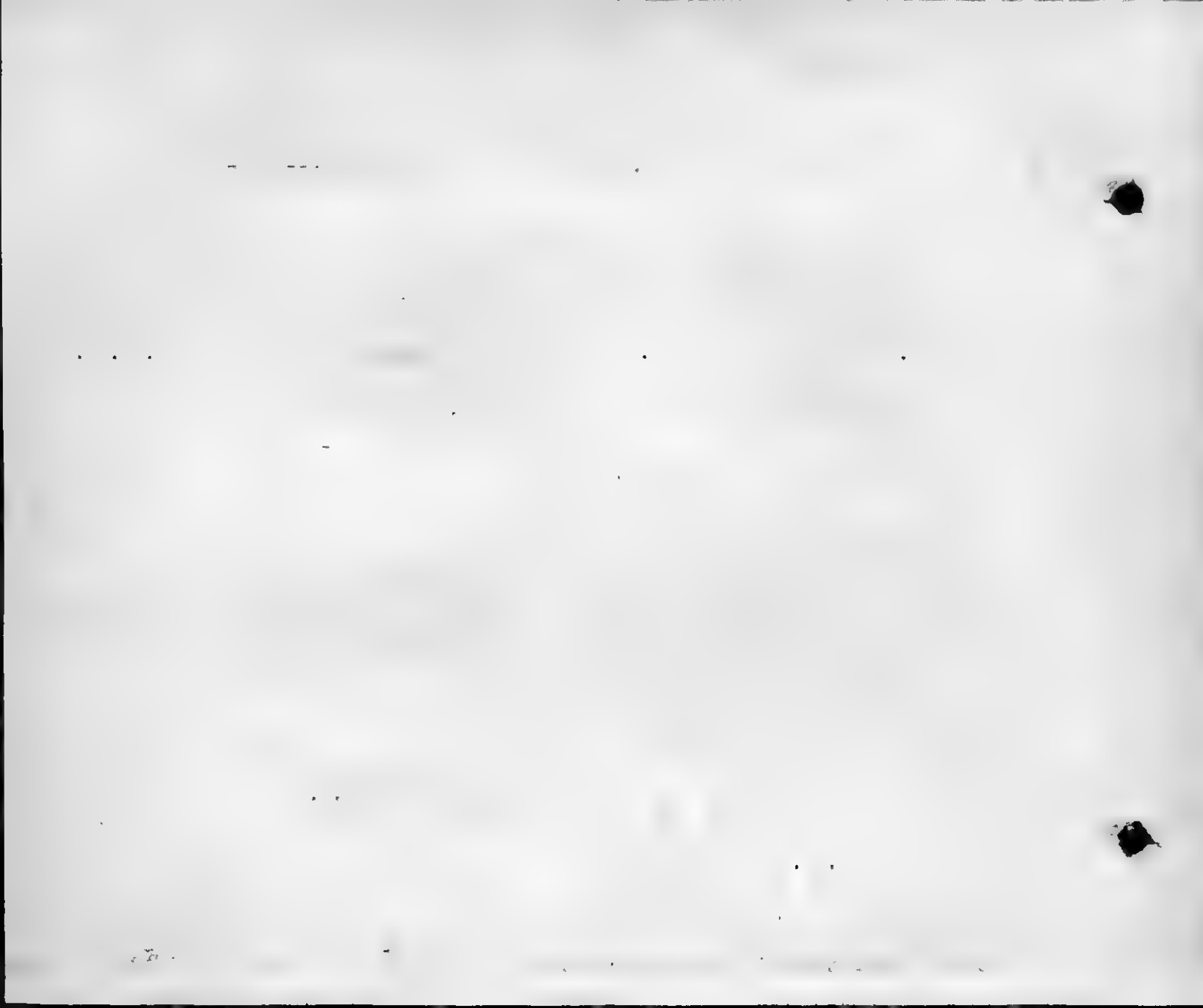
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Salisbury General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury (Rural)</u> d. STREET ADDRESS <u>Schumaker Road</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>ELIZABETH LETTY LOWE</u>		4. DATE OF DEATH Last First Middle Day Month Year <u>January 13 - 1962</u>		5. SEX <u>Female</u>	
6. RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. BIRTHDAY Last First Middle Year Month Day <u>Dec. 10, 1909</u>	
9a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		9b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		10. BIRTHPLACE (County & State, or foreign country) <u>Salisbury, Maryland</u>	
11. CITIZEN OF WHAT COUNTRY? <u>U S A</u>		12. FATHER'S NAME <u>Harry Lee Wilson</u>		13. MOTHER'S MAIDEN NAME <u>Ora E. Pollitt</u>	
14. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		15. SOCIAL SECURITY NO. <u>Mr. Charles M. Lowe (Husband) Schumaker Rd Salisbury, Maryland</u>		16. ADDRESS	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Failure</u> 2001 DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Posterior Coronary Occlusion</u> (a), stating the underlying cause last. DUE TO (c) <u>24 hrs</u>		18. INTERVAL BETWEEN ONSET OF DEATH <u>3 hrs</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		22. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	
23. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		24. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		25. (City or town) (County) (State)	
26. I certify that (1) (this hospital) attended the deceased from 1/12, 1962 to 1/13, 1962, that (2) (we) last saw the deceased alive on 1/13, 1962, and that death occurred at 5:30 P.M. from the causes and on the date stated above.		27. SIGNATURE <u>W. B. Smith</u> M.D.		28. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
29. PHYSICIAN'S NAME (Type) <u>Dr. William B. Smith</u>		30. ADDRESS <u>Salisbury, Maryland</u>		31. DATE SIGNED <u>1/13/62</u>	
32. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		33. DATE THEREOF <u>Jan. 16, 1962</u>		34. NAME OF CEMETERY OR CREMATORY <u>Pollitt Family Cemetery - R.D. # Salisbury, Md.</u>	
35. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		36. ADDRESS <u>SALISBURY, MARYLAND</u>		37. REC'D BY REGISTRAR <u>JAN 17 '62</u>	
38. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>		39. DATE <u>JAN 17 '62</u>		40. REGISTRAR'S SIGNATURE	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH															
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND															
CERTIFICATE OF DEATH															
01330				01313											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> <u>2342-2</u> d. STREET ADDRESS <u>513 Laurel Street</u>											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN TB <u>4Mos. 7Days</u>				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Deer's Head State Hospital</u>				a. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) <u>John Mays</u>				4. DATE OF DEATH <u>January 6 1962</u>				5. SEX <u>Male</u> 6. COLOR OR RACE <u>Negro</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>January 6, 1919</u> 9. AGE (In years last birthday) <u>43 yrs.</u> IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.							
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unk.</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Unk.</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Alabama</u>				12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
13. FATHER'S NAME <u>John Mays</u>				14. MOTHER'S MAIDEN NAME <u>Lucy Maibly</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>162-1</u>			
17. INFORMANT <u>Hospital Records -- Salisbury, Maryland</u> Address <u>Salisbury, Maryland</u>															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>162-1</u> IMMEDIATE CAUSE (e) <u>Bronchogenic carcinoma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>162-1</u> DUE TO (c) <u>162-1</u>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>162-1</u>															
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)															
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)															
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>															
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>															
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)															
20f. (City or town) (County) (State)															
21. I certify that (I) (his hospital) attended the deceased from <u>8/31/61</u> to <u>1/6/62</u> , 19....., that (I) (we) last saw the deceased alive on <u>1/6/62</u> , 19....., and that death occurred at <u>10:05 A.M.</u> from the causes and on the date stated above.															
22a. SIGNATURE <u>L. V. Maldve</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>January 6, 1962</u>															
22c. PHYSICIAN'S NAME (Type) <u>L. V. Maldve</u>															
22d. ADDRESS <u>Salisbury, Maryland</u>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>1-9-62</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill</u> 23d. LOCATION (City, town or county) (State) <u>Pocomoke, Md.</u>															
24. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u> ADDRESS <u>New Church, Va.</u>															
25. REC'D BY REGISTRAR <u>JAN 9 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Means</u>															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

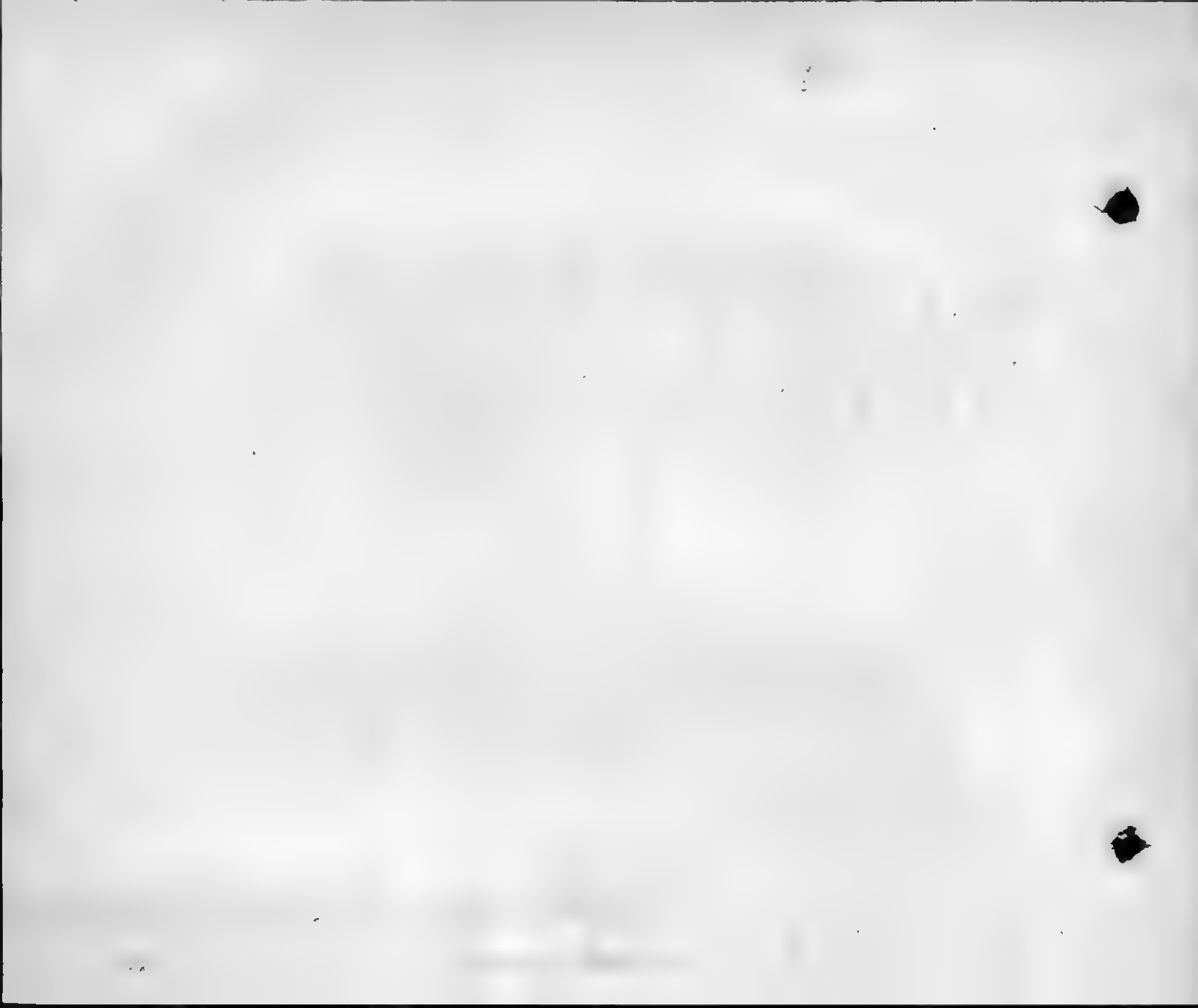
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01331

01314

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>2 WKS.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if out of corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> d. STREET ADDRESS <u>1112</u>			
3. NAME OF DECEASED (Type or print) <u>King B. Miller</u>		4. DATE OF DEATH Month <u>January</u> Day <u>12</u> Year <u>1962</u>		5. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
8. DATE OF BIRTH <u>Oct. 17, 1891</u>		9. AGE (In years last birthday) <u>70</u> yrs. IF UNDER 1 YEAR: Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Canner</u>			
10b. KIND OF BUSINESS OR INDUSTRY <u>Canning</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Kings Creek, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>Sydney Miller</u>		14. MOTHER'S M.A.DEN NAME <u>Margaret Barnes</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes give war or dates of service)</u>			
16. SOCIAL SECURITY NO. <u>King Miller, Jr., Princess Anne</u>		17. INFORMANT <u>King Miller, Jr., Princess Anne</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cirrhosis of the Liver</u> DUE TO <u>581.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>581.0</u> DUE TO <u>581.0</u> (c) <u>581.0</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		21. I certify that (I) (this hospital) attended the deceased from <u>1/2</u> to <u>1/12</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>1/11</u> , 19 <u>62</u> and that death occurred at <u>4:30</u> A.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>David J. Sekure</u>		22b. DATE SIGNED <u>1/12</u>		22c. PHYSICIAN'S NAME (Type) <u>David J. Sekure</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1/14/62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Presbyterian Cem. Princess Anne, Md.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Levin R. Wilson, Princess Anne, Md.</u>		25a. REC'D BY REGISTRAR <u>JAN 17 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Arthur P. Hume</u>			



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please
execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page
4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,
or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

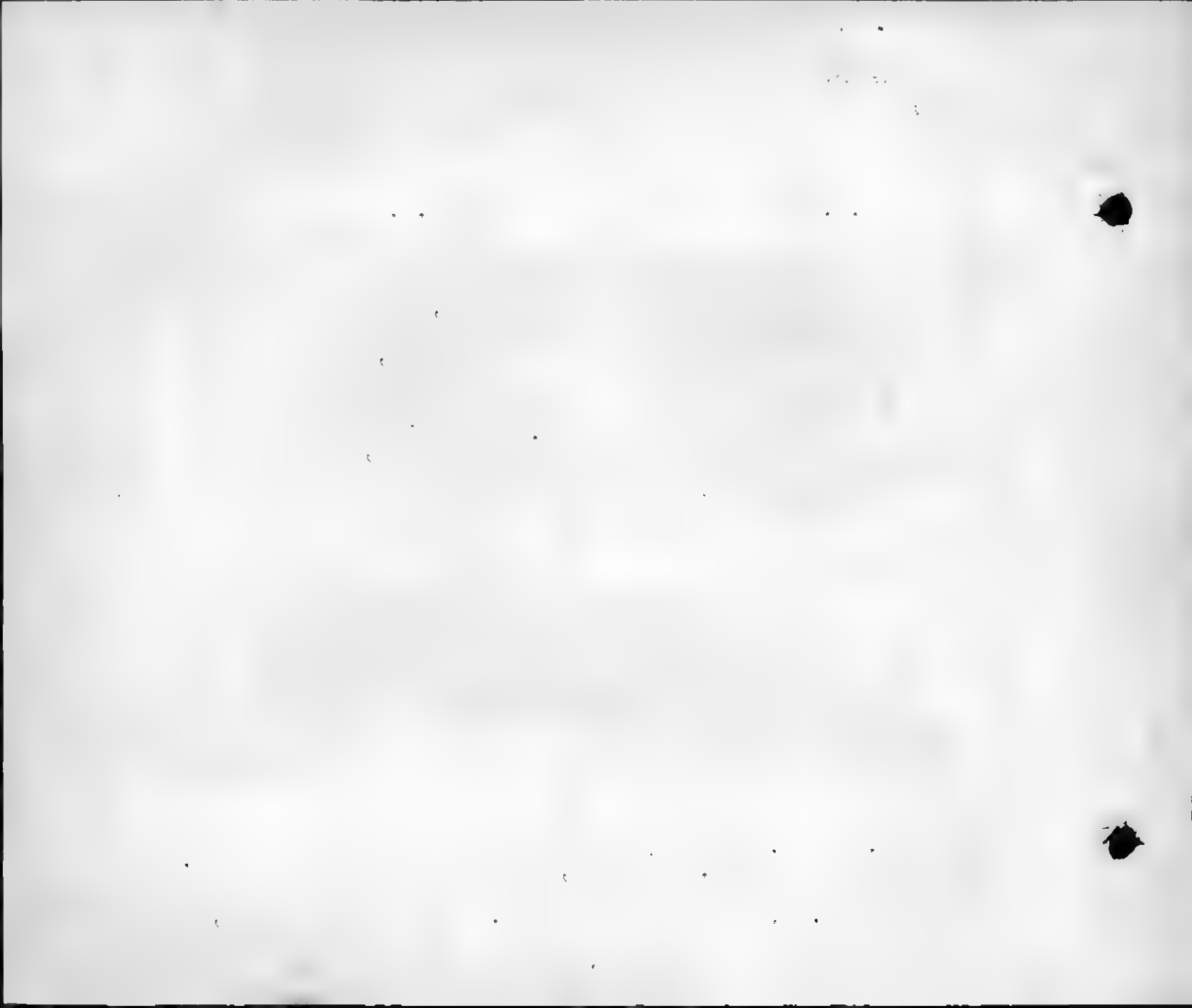
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01332

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Salisbury		c. LENGTH OF STAY IN 1b Salisbury (Rural)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 1		d. STREET ADDRESS R.D.# 1	
3. NAME OF DECEASED (Type or print) First Middle Last SIDNEY WILLIAM MORGAN		4. DATE OF DEATH Month Day Year JANUARY 22 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 8, 1877
9. AGE (in years last birthday) 84 yrs		10. IF UNDER 1 YEAR Months Days Hours Min. 10 14	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer—Meat Packing Plant		10b. KIND OF BUSINESS OR INDUSTRY Crisfield, Maryland	
11. BIRTHPLACE (State or foreign country) Crisfield, Maryland		12. CITIZEN OF WHAT COUNTRY U S A	
13. FATHER'S NAME Sidney Morgan		14. MOTHER'S MAIDEN NAME Elizabeth Young	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. Mr. Randall Morgan (Son) Abbott Drive Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 420.00 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Dr. Earl L. Royer EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 25, 1962		22b. DATE THEREOF 22c. NAME OF CEMETERY OR CREMATORY Crisfield Meth. Cemetery 22d. LOCATION (City, town, or county) (State) Crisfield, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY, MARYLAND		24a. REC'D BY REGISTRAR DATE JAN 26 '62 24b. REGISTRAR'S SIGNATURE Arthur L. Howard	

M

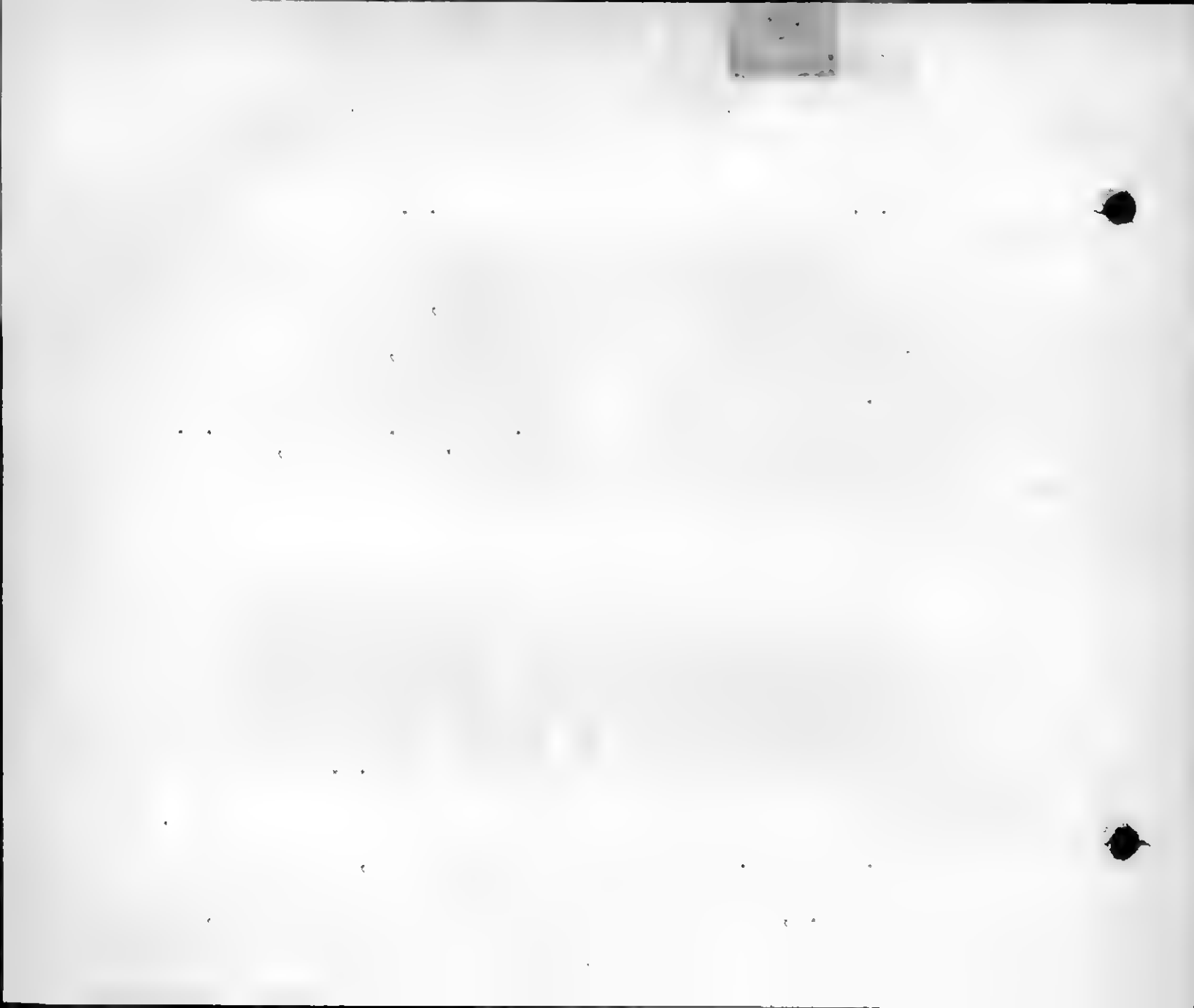
I



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01333
CERTIFICATE OF DEATH
01316

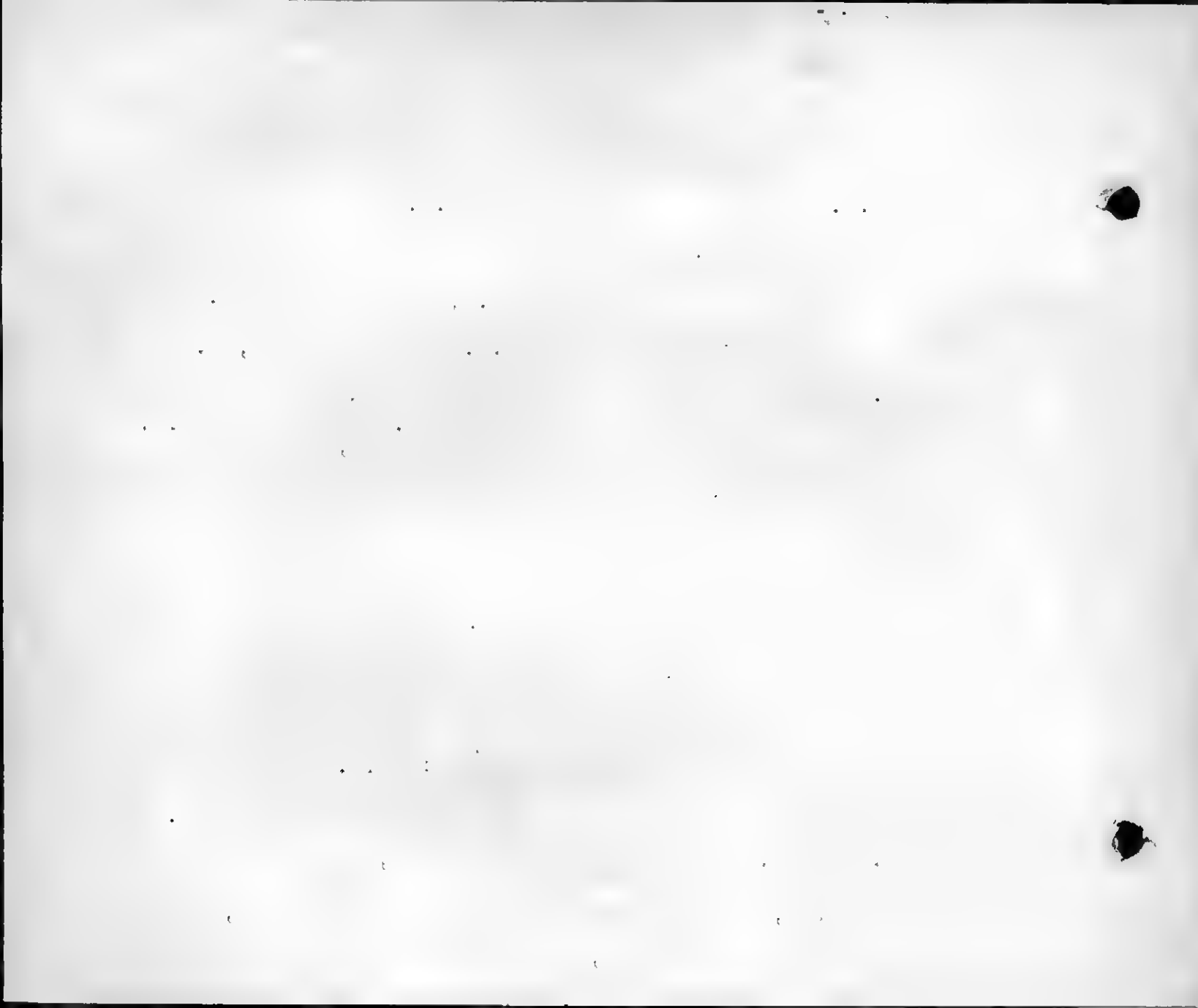
1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fruitland	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION P.O.Box# 44 (At Home)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MILTON Middle THOMAS Last OWENS		4. DATE OF DEATH Month JANUARY Day 5th Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 2, 1898
9. AGE (In years last birthday) 63 yrs.		10. IF UNDER 1 YEAR Months 63 Days 63 Hours 63 Min. 63	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Barber-Operated Own Shop		10b. KIND OF BUSINESS OR INDUSTRY Shop	
11. BIRTHPLACE (State or foreign country) Cambridge, Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME William E. Owens		14. MOTHER'S MAIDEN NAME Fannie Cora Carpenter	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk		16. SOCIAL SECURITY NO. Unk	
17. INFORMANT Mrs. Beulah H. Owens (Wife) Address P.O.Box#44 Main St. Fruitland, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CORONARY Thrombosis 420 - 1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) 420 - 1 DUE TO (c) 420 - 1	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 420 - 1		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. N/A p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) N/A (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Jan 5 8:10 A.M. Jan 5 1962 that (I) (we) last saw the deceased alive on Jan 5 1962 and that death occurred at Jan 5 1962 from the causes and on the date stated above.			
22a. SIGNATURE Dr. Robert T. Adkins		22b. DATE SIGNED Jan. 1 1962	
22c. PHYSICIAN'S NAME (Type) Dr. Robert T. Adkins		22d. ADDRESS Fruitland, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 7, 1962	
23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town, or county) Salisbury, Maryland (State)	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		ADDRESS SALISBURY, MARYLAND	
25a. REC'D BY REGISTRAR JAN 8 '62		25b. REGISTRAR'S SIGNATURE W. L. Thomas	



TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

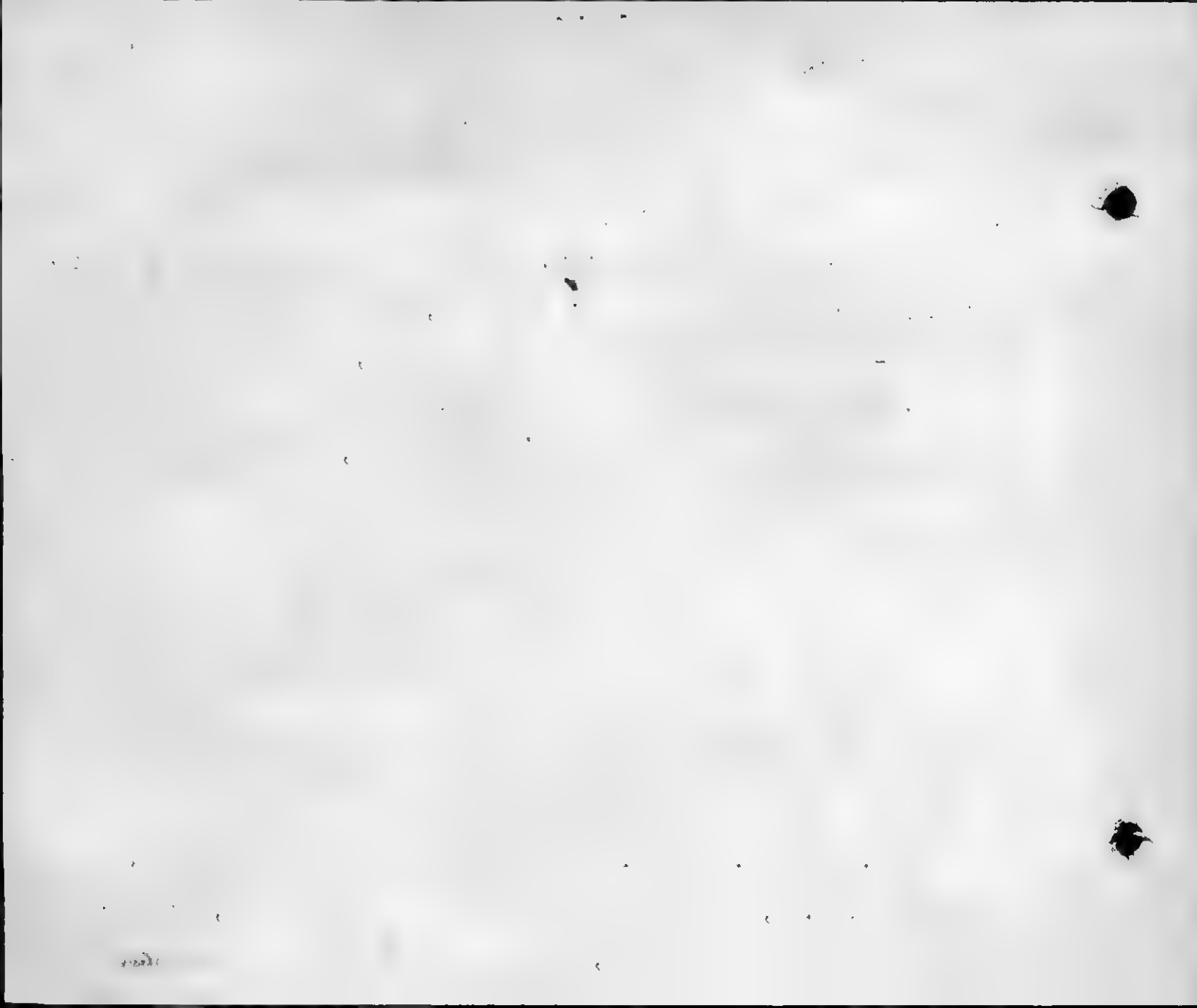
1
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
01334
CERTIFICATE OF DEATH
01317

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Parsonsborg	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.# 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3 NAME OF DECEASED (Type or print) First MIDDLE Last LARRY PRETTYMAN PARKER		4. DATE OF DEATH Month Day Year JANUARY 26th 1962	
5 SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 9, 1882
9. AGE (In years last birthday) 79 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min. 4 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant		10b. KIND OF BUSINESS OR INDUSTRY Grocery Store	
11. BIRTHPLACE (State or foreign country) R.D.# 1 Parsonsborg, Md.		12. CITIZEN OF WHAT COUNTRY? U S A	
13 FATHER'S NAME Joshua J. Parker		14 MOTHER'S MAIDEN NAME Lavenia Workman	
15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO .	
17. INFORMANT Miss Delia M. Parker (Sister) R.D.# 1 Parsonsborg, Maryland		Address	
18 CAUSE OF DEATH [Enter only one cause, per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 422.2 CHRONIC MYOCARDITIS DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH 1	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ upper respiratory (viral) infection		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) N/A	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. N/A 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) N/A		20f. (City or town) (County) (State) N/A	
21. I certify that (I) (this hospital) attended the deceased from Jan 1 1962 to 1-26-1962 that (I) (we) last saw the deceased alive on 1-25-1962 and that death occurred at 2:00 A.M. from the causes and on the date stated above.			
22a SIGNATURE Frank Lewis		22b DATE SIGNED Jan. 27 / 1962	
22c PHYSICIAN'S NAME (Type) Dr. Frank R. Lewis		22d ADDRESS Willards, Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial Jan. 29, 1962		23b. DATE THEREOF	
23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		23d. LOCATION (City, town, or county) (State) Salisbury, Maryland	
24 FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR DATE JAN 30 '62	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE Arthur P. Lewis	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers and 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
01335											
01335											
1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>MARYLAND</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>											
2. USUAL RESIDENCE (Where deceased lived, if institution; Residence Before Admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PARSONS BURG</u> d. STREET ADDRESS <u>Route #50 (In Village)</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <u>LOUISE ELIZABETH PARSONS</u> 4. DATE OF DEATH <u>JANUARY 7 1962</u> 5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>WHITE</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>August 2, 1901</u> 9. AGE (In years last birthday) <u>60</u> yrs. IF UNDER 1 YEAR Months Days Hours Min. IF UNDER 24 HRS.											
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Secretary-Real Estate Office</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Parsonsburg, Maryland</u> 11. BIRTHPLACE (Country & State, or foreign country) <u>U S A</u> 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>											
13. FATHER'S NAME <u>Laird W. Parsons (Deceased)</u> 14. MOTHER'S MAIDEN NAME <u>Carrie Bailey</u> 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> 16. SOCIAL SECURITY NO. <u>INFORMANT Mrs. Carrie Parsons (Mother) Parsonsburg, Maryland</u>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 525 X IMMEDIATE CAUSE (a) <u>Pneumonia - due to Proleus</u> Conditions, if any, which gave rise to immediate cause (b) <u>Acute Interstitial Fibrosis</u> (c) <u>(Hamman - Rich Disease)</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>N/A</u> 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>N/A 19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town, (County) (State)											
21. I certify that (I) (the hospital) attended the deceased from <u>May 1957</u> to <u>Jan 7, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 7, 1962</u> , and that death occurred at <u>11:30 PM</u> , from the causes and on the date stated above.											
22a. SIGNATURE <u>Thomas C. Hill Jr.</u> M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> 22b. DATE SIGNED <u>1/7/62</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. Thomas C. Hill Jr.</u> 22d. ADDRESS <u>Pine Bluff Road Salisbury, Maryland</u>											
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> 23b. DATE THEREOF <u>Jan. 10, 1962</u> 23c. NAME OF CEMETERY OR CREMATORY <u>Parsonsburg Cemetery</u> 23d. LOCATION (City, town or county) (State) <u>Parsonsburg, Maryland</u>											
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u> 25a. REC'D BY REGISTRAR <u>JAN 9 '62</u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>											



1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

(M)

X

MARYLAND STATE DEPARTMENT OF HEALTH			
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND			
01336		01310	
1. PLACE OF DEATH		2. USUAL RESIDENCE (Where deceased lived, if not usual residence before admission)	
a. COUNTY	Wicomico	a. STATE	Maryland
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	Willards	b. COUNTY	Wicomico
c. LENGTH OF STAY IN 1b	25Yrs	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	X Willards
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)	XX	d. STREET ADDRESS	RFD
3. NAME OF DECEASED (Type or print)	ROBERTA FRANCES PETERSON	4. DATE OF DEATH	Jan. 5, 1962
5. SEX	Female	6. COLOR OR RACE	White
7. MARRIED	<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	Sept. 29, 1919
9. AGE (In years last birthday)	42 yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	Housewife
11. BIRTHPLACE (County & State or foreign country)	Maryland	12. CITIZEN OF WHAT COUNTRY?	USA
13. FATHER'S NAME	Robert Houston	14. MOTHER'S MAIDEN NAME	Una Ward
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)	XX XX	16. SOCIAL SECURITY NO.	XX
17. INFORMANT	Stura Peterson Willards, Md.	18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)	Chronic myocarditis
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO (b)	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY	Month, Day, Year	20d. INJURY OCCURRED	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
Hour a.m. p.m.	19	White <input type="checkbox"/> Not White <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 1955 to 1962, that (I) (we) last saw the deceased alive on 1-5-62, and that death occurred at 1:15 P.M., from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
Frank Lewis		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS	
NAME (Type)		Willards Maryland	
23a. BURIAL, CREMATION, 23b. DATE THEREOF REMOVAL (Specify)		23c. NAME OF CEMETERY OR CREMATORY	
Burial 1/8/62		New Hope	
24. FUNERAL DIRECTOR'S SIGNATURE		25a. REC'D BY REGISTRAR	
Peter Whaley		JAN 9 '62	
25b. REGISTRAR'S SIGNATURE		26. REGISTRAR'S SIGNATURE	
Arthur E. Thomas		Arthur E. Thomas	

VR A15 (4)
15M 9/60



1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute a "pending" certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01337

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01320

1. PLACE OF DEATH
a. COUNTY

Wicomico

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Salisbury

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)

Peninsula General Hospital

3. NAME OF DECEASED
(Type or print)

John Clifford Postley

5. SEX

6. COLOR OR RACE

7. MARRIED ☒ NEVER MARRIED ☐

8. DATE OF BIRTH

9. AGE (In years last birthday)

IF UNDER 1 YEAR

IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country)

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME

14. MOTHER'S MAIDEN NAME

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give year or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute pulmonary edema

Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last.

Aortic stenosis.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE

Earl L. Royer, M.D.

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

EXAMINER'S NAME (Type)

407 Camden Ave. Salisbury Md.

Address (Street, city, town, or county)

1-3-62

22. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY

22d. LOCATION (City, town, or county)

(State)

23. FUNERAL DIRECTOR

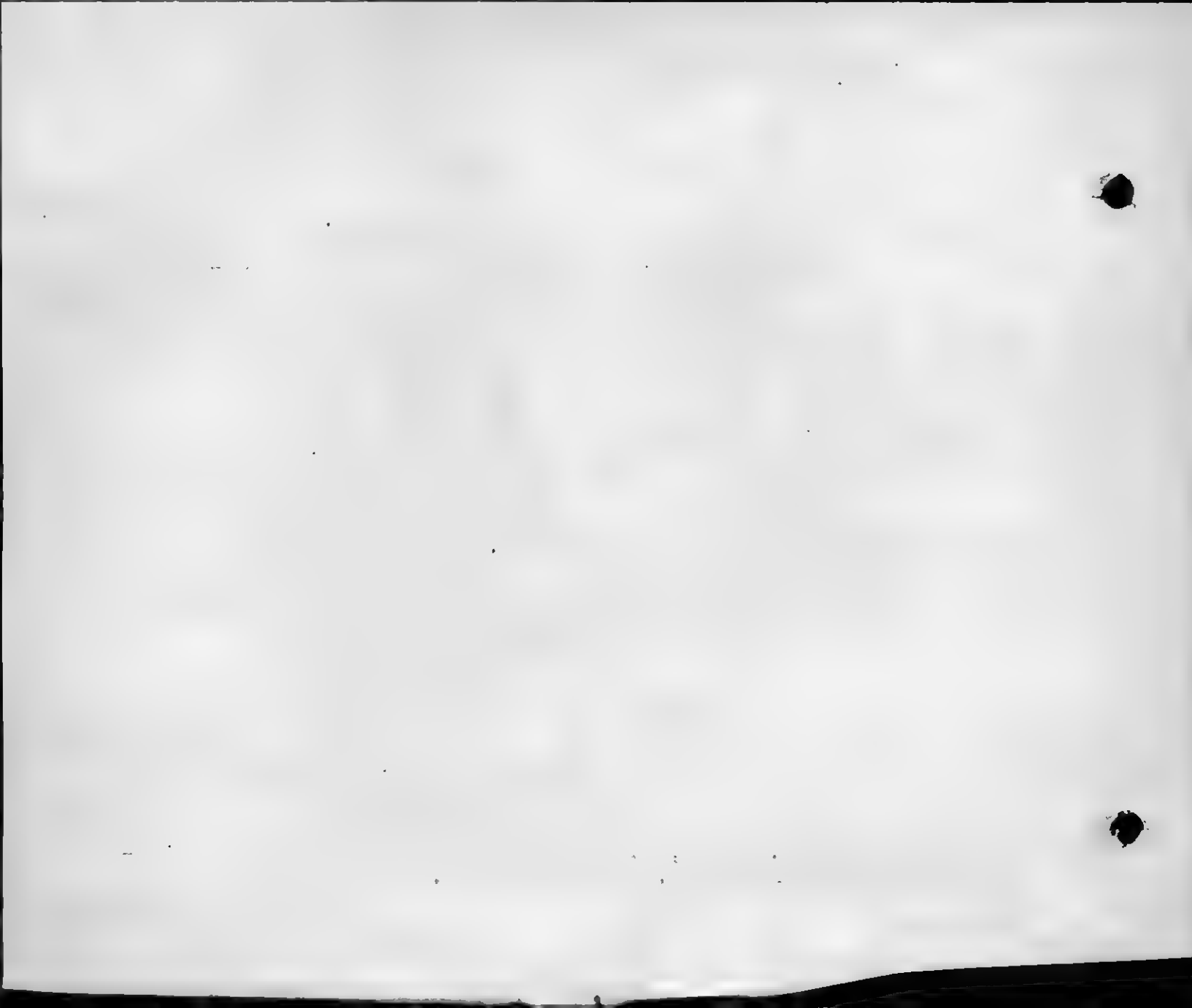
ADDRESS

24a. REC'D BY REG STRAR

24b. REGISTRAR'S SIGNATURE

JAN 8 '62

Arthur L. House



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01338

02537

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY in b <u>3,117 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u> d. STREET ADDRESS <u>RFD</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Page E. Pusey</u>		4. DATE OF DEATH Month <u>January</u> Day <u>31</u> Year <u>19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 8. DATE OF BIRTH <u>1872</u>	9. AGE (In years last birthday) <u>89</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sawyer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber</u>	11. BIRTHPLACE County & State, or foreign country <u>Maryland</u>
13. FATHER'S NAME <u>Levin Pusey</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>Arteriosclerosis, general</u>		17. INFORMANT Address <u>Mrs. Lola Gaylor, Washington, D. C.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: a)		INTERVAL BETWEEN ONSET AND DEATH <u>12 hours</u> <u>Years</u> <u>Years</u>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>July 20</u> , 19 <u>53</u> , to <u>Jan. 31</u> , 19 <u>62</u> that (I) (we) last saw the deceased alive on <u>Jan. 31</u> , 19 <u>62</u> , and that death occurred at <u>10:37 P.M.</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>V. Guerman</u>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22b. DATE SIGNED <u>2/1/62</u>
22c. PHYSICIAN'S NAME (Type) <u>V. Guerman, M. D.</u>		22d. ADDRESS <u>Deer's Head Hospital; Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>2/3/62</u>	23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Marion Station, Md.</u>
24 FUNERAL DIRECTOR'S SIGNATURE <u>Bradshaw & Sons, Crisfield, Md.</u>		25a. REC'D BY REGISTRAR <u>FEB 7 '62</u> 25b. REGISTRAR'S SIGNATURE <u>William L. Hines</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

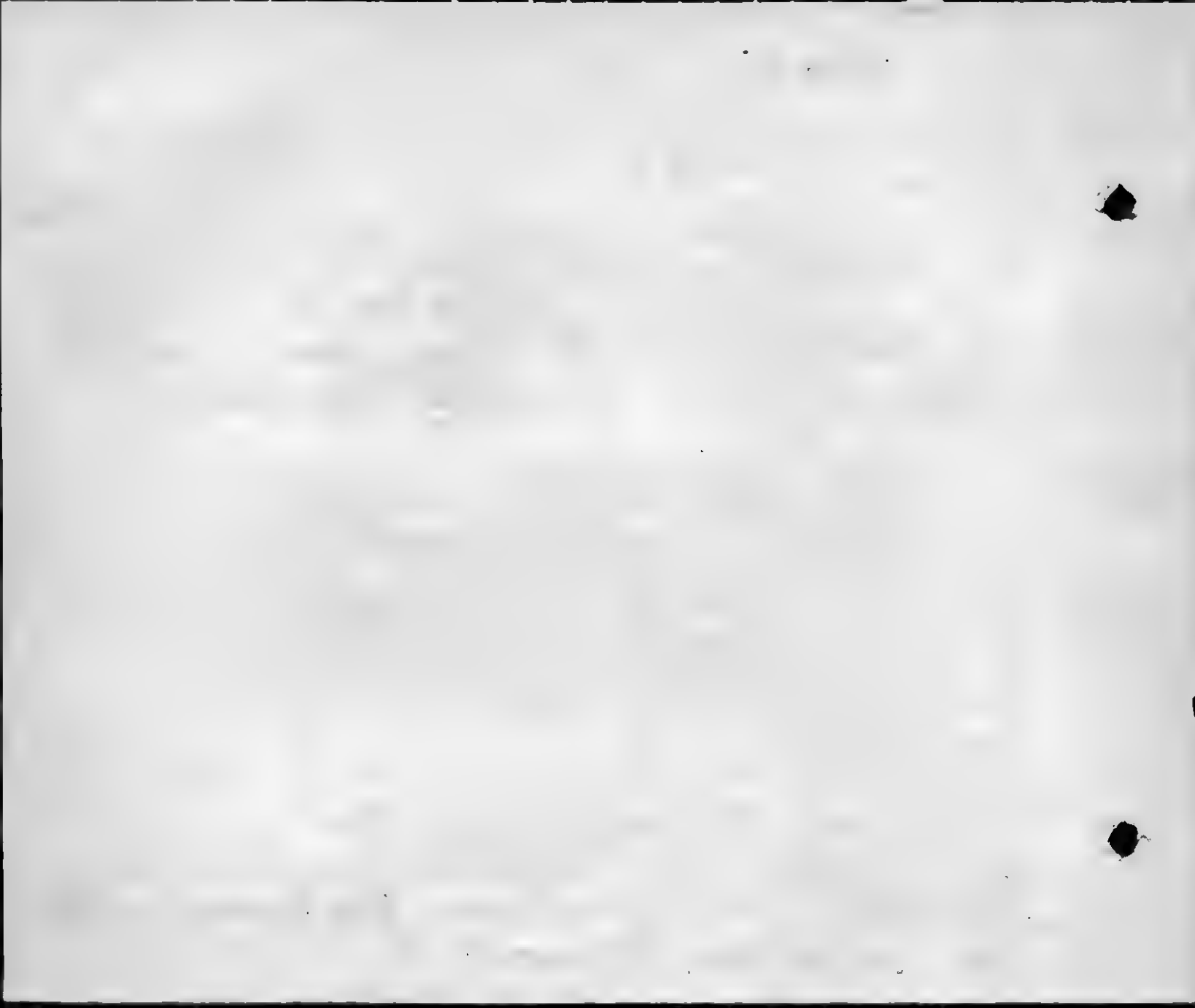
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01339

CERTIFICATE OF DEATH

01321

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN b. <u>4 mo</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Maryland</u> f. COUNTY <u>Wicomico</u> g. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> h. STREET ADDRESS <u>204 Hayward Ave</u>		i. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Beatrice Ethel Penshaw</u> First Middle Last		4. DATE OF DEATH <u>January 1, 1962</u> Month Day Year		5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u> 9a. AGE (In years, last birthday) <u>54</u> yrs. 9b. IF UNDER 1 YEAR Months Days 9c. IF UNDER 24 HRS. Hours Min.		10. KIND OF BUSINESS OR INDUSTRY 11. PLACE OF BIRTH (Country & State or foreign country) <u>Maryland</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>		13. FATHER'S NAME <u>Ellwood</u> 14. MOTHER'S MAIDEN NAME <u>May Townsend</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> 16. SOCIAL SECURITY NO. <input type="checkbox"/> 17. INFORMANT <u>May Townsend</u> Address		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary edema</u> DUE TO (b) <u>Congestive heart failure</u> DUE TO (c) <u>Diabetes mellitus</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a):			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>3 wks</u> <u>12 yrs</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Hour <u>19</u> a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 1, 1961</u>, to <u>Jan. 1, 1962</u>, that (I) (we) last saw the deceased alive on <u>Jan. 1, 1962</u>, and that death occurred at <u>12:00 PM</u> from the causes and on the date stated above.					
22a. SIGNATURE <u>George A. Henning</u> M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		22d. ADDRESS <u>Fruitland, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-4-62</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Grace Cemetery</u>	
23d. LOCATION (City, town or county) <u>Mt Vernon, Md</u>		23e. (State)			
24. FUNERAL DIRECTOR'S SIGNATURE <u>Lewis R. Wilson</u>		25. REC'D BY REGISTRAR <u>Jan 8 '62</u>		25b. REGISTRAR'S SIGNATURE <u>Robert J. Thomas</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

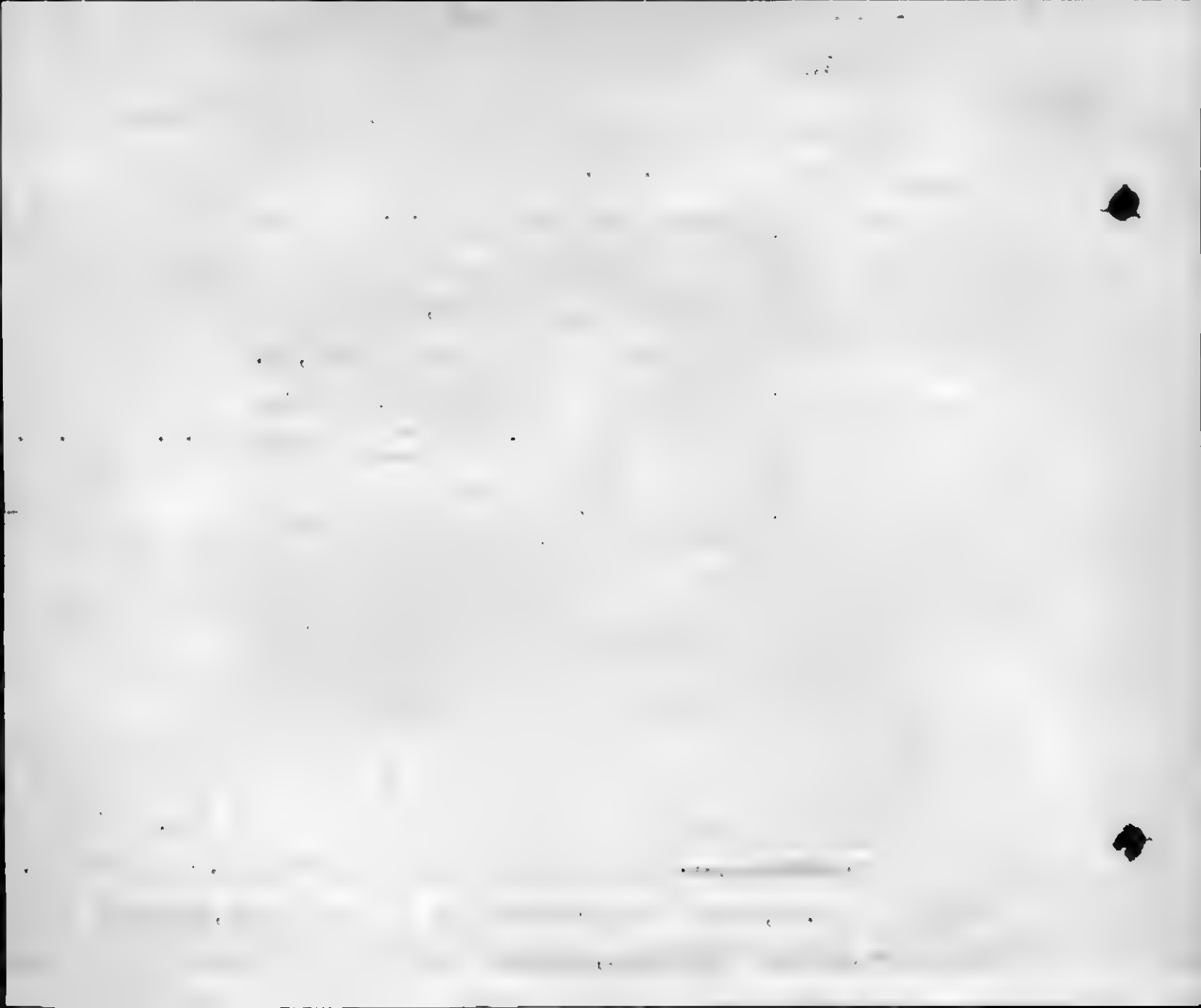
01340

01322

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside of corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
c. LENGTH OF STAY in 1b <u>2Yrs.9Mos.10Days</u>		d. STREET ADDRESS <u>R.D.# 5 (Quantico Rd)</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Emma Frances Richardson</u>		4. DATE OF DEATH <u>January 26 19 1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <u>WIDOWED</u> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 10, 1877</u>
9. AGE (In years last birthday) <u>84</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work at Home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Wicomico County, Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U S A</u>	
13. FATHER'S NAME <u>Henry Clay Mills</u>		14. MOTHER'S MAIDEN NAME <u>Mary Ellen Phillips</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u> </u>	
17. INFORMANT <u>Mrs. Roxie Wells (Daughter)</u>		Address <u>R.D.#5 Sal. Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia - Chronic</u> 332x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis, General</u> DUE TO (c) <u> </u>		INTERVAL BETWEEN ONSET AND DEATH <u>Month's</u> <u>Years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recurrent Cerebral Thrombosis due to arteriosclerosis</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u> </u> <u> </u> <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	20f. (City or town) (County) (State) <u> </u> <u> </u> <u> </u>
21. I certify that (I) (this hospital) attended the deceased from <u>1/21/59</u> , 19 <u> </u> , to <u>1/26/62</u> , 19 <u> </u> , that (I) (we) last saw the deceased alive on <u>1/26/62</u> , 19 <u> </u> , and that death occurred at <u>5P</u> M, from the causes and on the date stated above.			
22a. SIGNATURE <u>V. Juerman</u>		22b. DATE SIGNED <u>Jan. 26/1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M.D.</u>		22d. ADDRESS <u>Deer's Head State Hosp. - Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Jan. 29, 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u>	23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u>		25a. REC'D BY REGISTRAR DATE <u>JAN 30 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

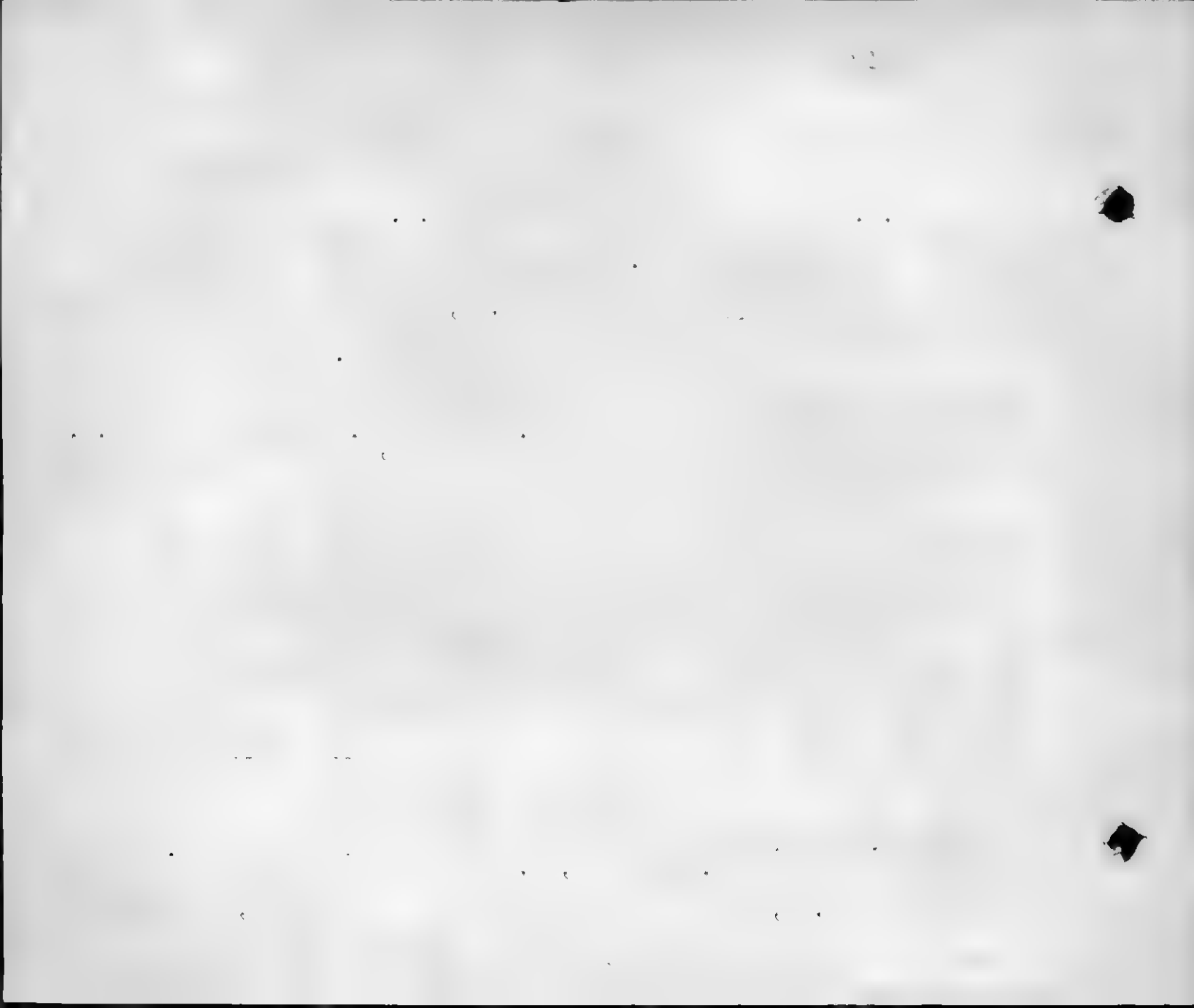


FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

<div>Items 18-21 Film 305</div> <div>1-22-62 AMS</div> <div>305</div> <div>Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</div> <div>01341 MEDICAL EXAMINER'S CERTIFICATE OF DEATH</div> <div>01323</div>											
1. PLACE OF DEATH a. COUNTY Wicomico				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury				c. LENGTH OF STAY IN 1b				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury (Rural)			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) R.D.# 1				d. STREET ADDRESS R.D.# 1				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) ERNEST				First Middle Last H. RIGGIN				4. DATE OF DEATH Month JANUARY Day 8 Year 1962			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Nov. 25, 1889		9. AGE (In years last birthday) 72 yrs.		IF UNDER 1 YEAR Months 1 Days 13 Hours Min. 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer				10b. KIND OF BUSINESS OR INDUSTRY Farming				11. BIRTHPLACE (State or foreign country) Worcester Co. Maryland		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Sidney Riggin				14. MOTHER'S MAIDEN NAME Martha Timmonds							
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No				16. SOCIAL SECURITY NO.				17. INFORMANT Mrs. Katherine A. Howard (Daughter) R.D.#2 Snow Hill, Maryland			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Exposure to cold 932.0 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Second degree burns of 15% body surface										INTERVAL BETWEEN ONSET AND DEATH Hours	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Found dead in unheated shack. Apparently had scalded himself with hot liquid							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 1 6 19 62		20d. INJURY OCCURRED Where <input type="checkbox"/> Not Where <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) Wicomico Md.		(County)		(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dr. Earl I. Royer				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED Jan. 10 / 1962			
EXAMINER'S NAME (Type) 407 Camden Ave. Salisbury, Md.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				Address (Street, city, town, or county)			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) Burial		22b. DATE THEREOF Jan. 11, 1962		22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery		22d. LOCATION (City, town, or country) Salisbury, Maryland		(State)			
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY, MARYLAND				ADDRESS		24a. REC'D BY REGISTRAR JAN 17 '62		24b. REGISTRAR'S SIGNATURE Arthur L. Howard			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

01343

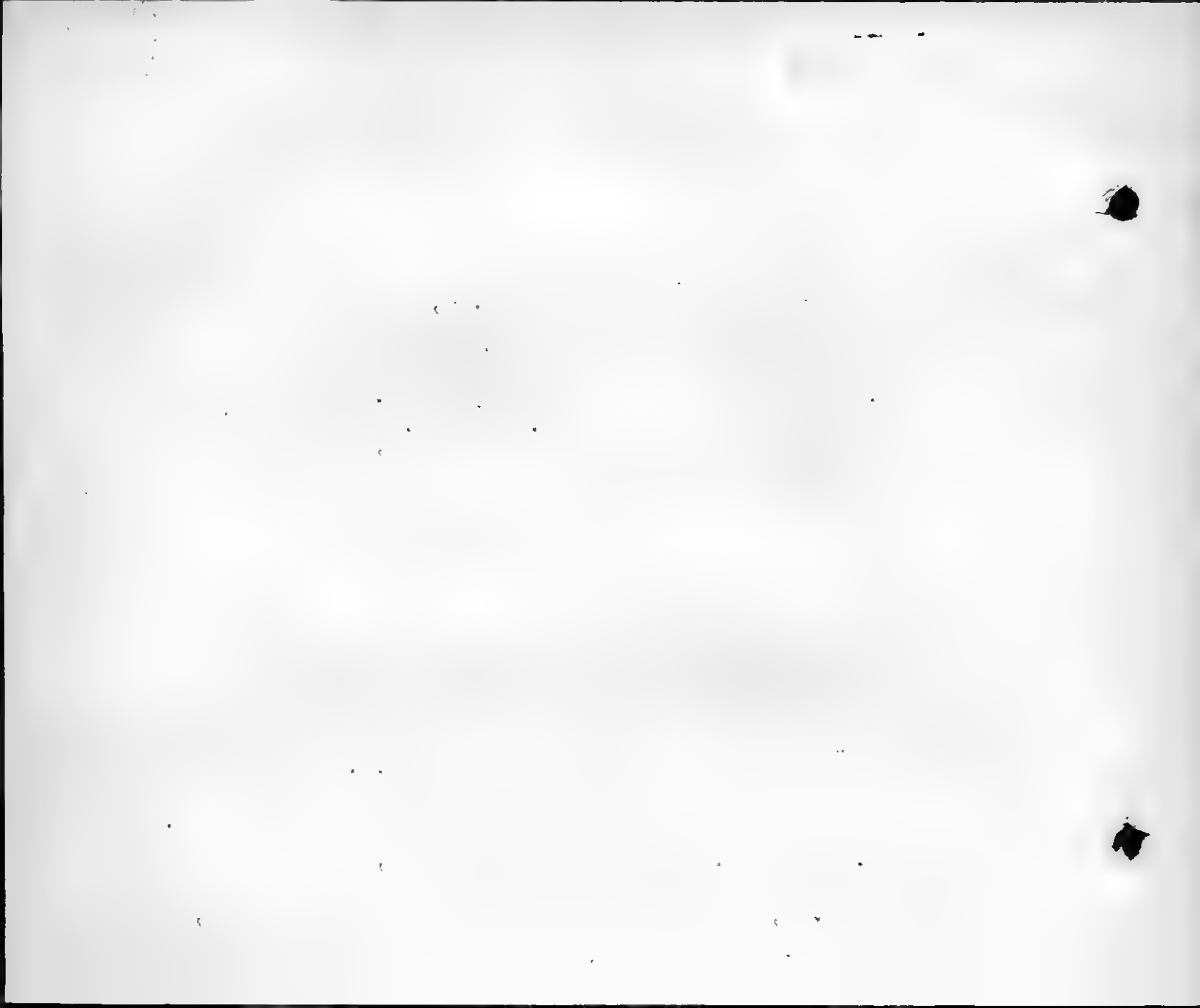
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1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen Hospital		d. STREET ADDRESS 734 Roger St	
3. NAME OF DECEASED (Type or print) First ALICE Middle MEADE Last ROSS		4. DATE OF DEATH Month JANUARY Day 16th Year 19 62	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 4, 1877
9. AGE (In years last birthday) 84 yrs.		IF UNDER 1 YEAR Months 4 Days 12	IF UNDER 24 HRS. Hours Min
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home		10b. KIND OF BUSINESS OR INDUSTRY None	11. BIRTHPLACE (State or foreign country) New Jersey
12. CITIZEN OF WHAT COUNTRY? U S A			
13. FATHER'S NAME Stephen B. Howell		14. MOTHER'S MAIDEN NAME Margaret V. Patrey	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO 	
17. INFORMANT Mr. Howard G. Ross (Husband)		Address 734 Rogers St Salisbury, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency DUE TO 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Intestinal Obstruction DUE TO (c) Carcinoma Colon			INTERVAL BETWEEN ONSET AND DEATH 2 days 5 days 1 yr.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) N/A		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. 	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 	20f. (City or town) (County) (State)
21 I certify that (I) (this hospital) attended the deceased from 1/3 1962 to 1/16 19 62 that (I) (we) last saw the deceased alive on 1/16 19 62 and that death occurred at 3:52 A.M. from the causes and on the date stated above.			
22a SIGNATURE W. B. Smith		22b DATE SIGNED Jan. 17 1962	
22c PHYSICIAN'S NAME (Type) Dr. William B. Smith		22d ADDRESS Salisbury, Maryland	
23a BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE THEREOF Jan. 19, 1962	23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park	23d. LOCATION (City, town, or county) (State) Salisbury, Maryland
24. FUNERAL DIRECTOR'S SIGNATURE HOTLOWAY & COMPANY		25a. REC'D BY REGISTRAR AN 1 9 '62	
ADDRESS SALISBURY, MARYLAND		25b REGISTRAR'S SIGNATURE William S. Thomas	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

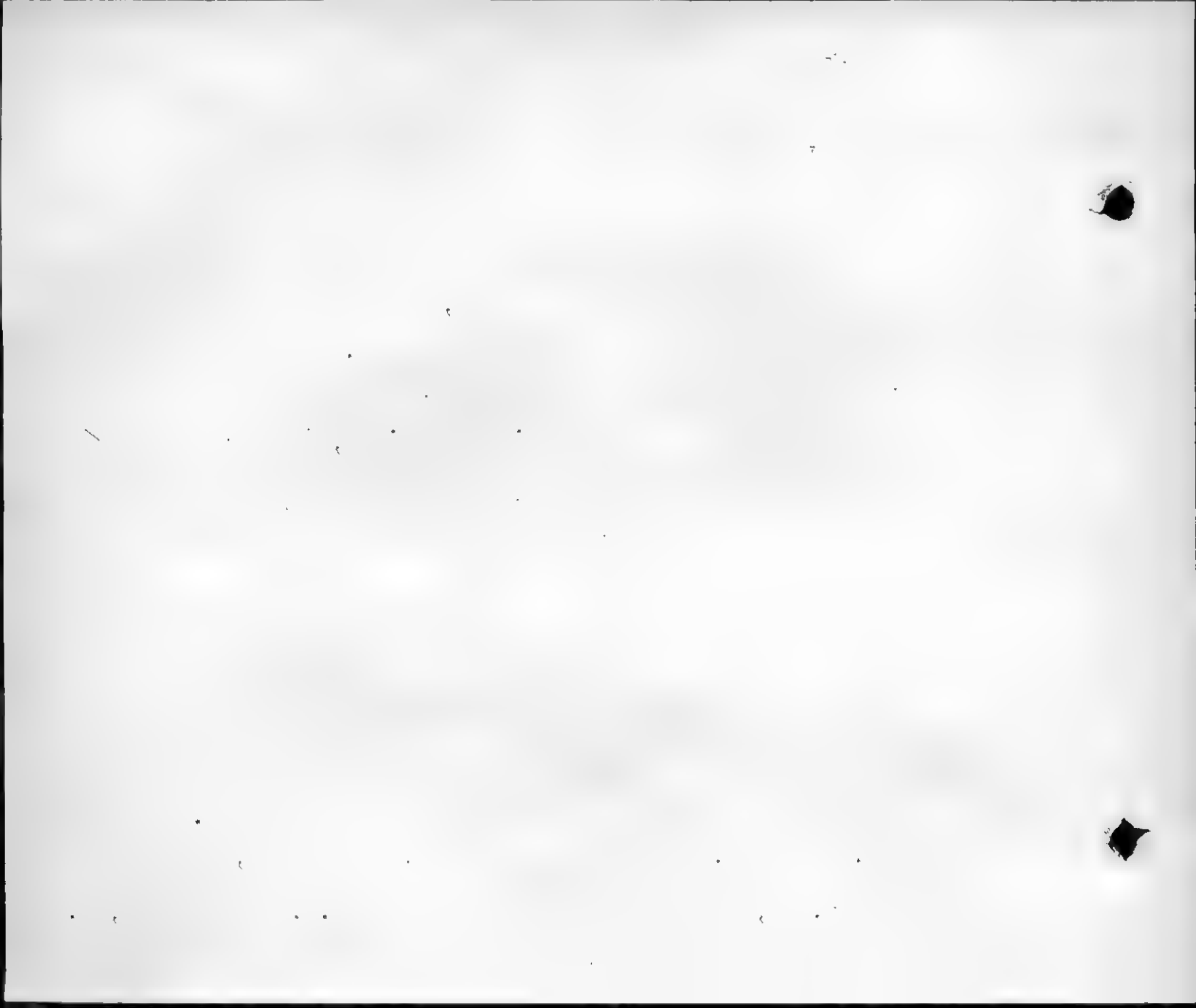
VR AIS (4)
ISM 9/59

01344

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01326

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsborg		c. LENGTH OF STAY IN 1b X	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION In Village		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JOHN Middle BENJAMIN Last SHOCKLEY		4. DATE OF DEATH Month JANUARY Day 16 Year 19 62	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 4, 1884
9. AGE (In years lost birthday) 77 yrs.		10. IF UNDER 1 YEAR: Months 7 Days 12 Hours Min 	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer & Carpenter		10b. KIND OF BUSINESS OR INDUSTRY Wicomico Co. Maryland	
11. BIRTHPLACE (State or foreign country) U S A		12. CITIZEN OF WHAT COUNTRY? U S A	
13. FATHER'S NAME Emory Shockley		14. MOTHER'S MAIDEN NAME Lavenia Figgs	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) unk		16. SOCIAL SECURITY NO. 	
17. INFORMANT Mrs. Amanda M. Shockley (Wife) Parsonsborg, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420 Coronary thrombosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio-sclerotic heart disease (c) 	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) N/A		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) 	
20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 		20f. (City or town) (County) (State) 	
21 I certify that (I) (this hospital) attended the deceased from 1-15-1962 to 1-16-1962 , that (I) (we) last saw the deceased alive on 1-15-1962 , and that death occurred at M , from the causes and on the date stated above.			
22a. SIGNATURE Philip A. Insley		22b. DATE SIGNED Jan. 17 / 1962	
22c. PHYSICIAN'S NAME (Type) Dr. Philip A. Insley		22d. ADDRESS Main St. Salisbury, Maryland	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial Jan. 19, 1962		23b. DATE THEREOF Jan. 19, 1962	
23c. NAME OF CEMETERY OR CREMATORY Line Church Cemetery - R.D. # Pittsville, Md.		23d. LOCATION (City, town, or county) (State) 	
24. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY		25a. REC'D BY REGISTRAR JAN 22 1962	
ADDRESS SALISBURY, MARYLAND		25b. REGISTRAR'S SIGNATURE 	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

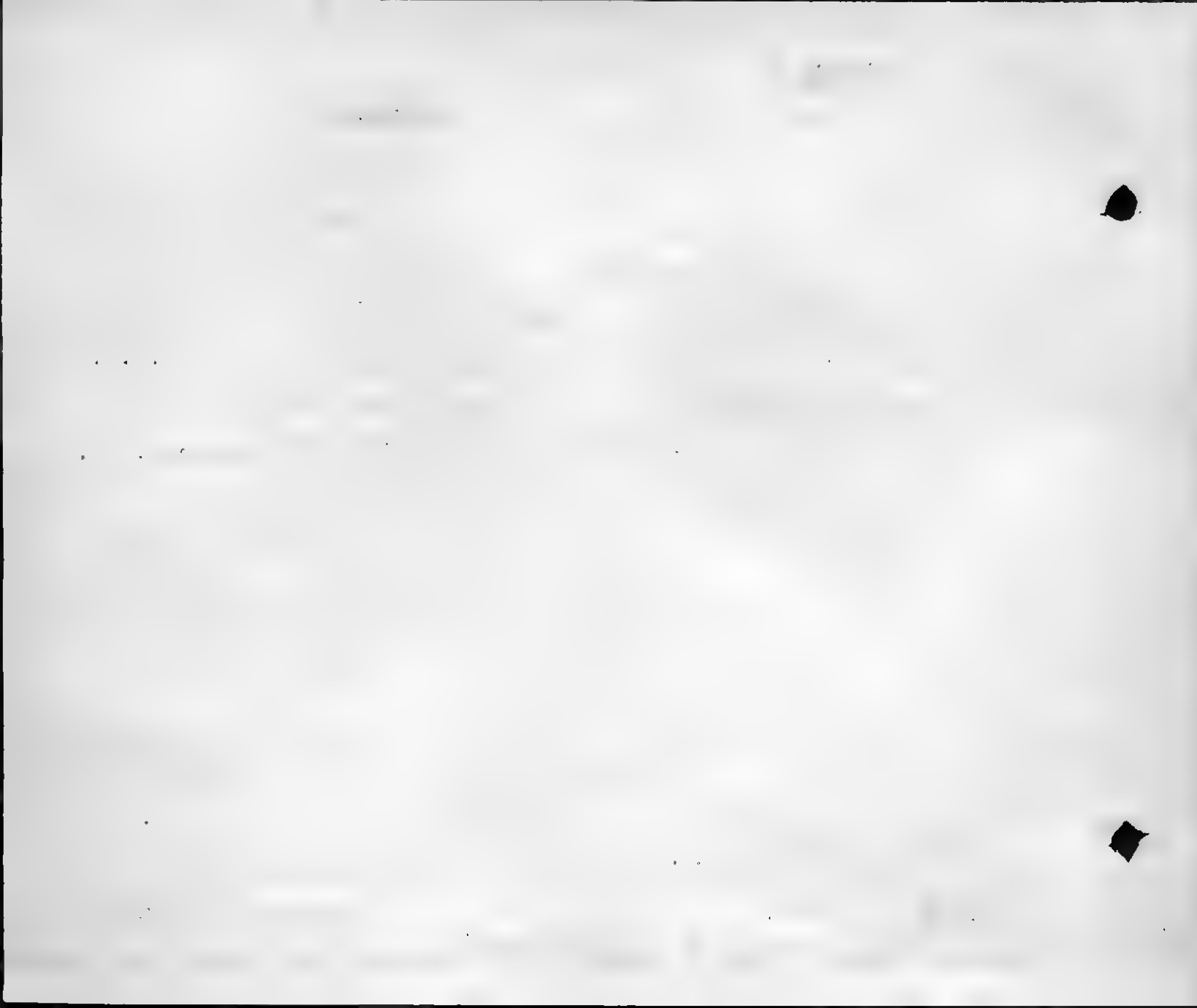
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01345

01327

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Caroline</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury, Maryland</u>		c. LENGTH OF STAY IN 1b <u>1yr 6mo 28days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>		d. STREET ADDRESS <u>Ridgely</u>	
3. NAME OF DECEASED (Type or print) First <u>Ella</u> Middle <u>Elizabeth</u> Last <u>Smith</u>		4. DATE OF DEATH Month <u>Jan</u> Day <u>6</u> Year <u>1962</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 24, 1883</u>
9. AGE (In years last birthday) <u>78</u> yrs.		10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u>	11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles H. White</u>		14. MOTHER'S MAIDEN NAME <u>Anna Ritter Mattee</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-01-4113</u>	
17. INFORMANT <u>Edward Smith</u>		Address <u>Ridgely, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinome of breast with general metastases</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> (c) <u> </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u> </u> 19 <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>June 9, 1960</u> to <u>Jan 6, 1962</u> , that (I) (we) last saw the deceased alive on <u>Jan 6, 1962</u> , and that death occurred at <u>3P.M.</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>L. Maldve</u>		22b. DATE SIGNED <u>Jan. 7, 1962</u>	
22c. PHYSICIAN'S NAME (Type) <u>L. Maldve, M.D.</u>		22d. ADDRESS <u>Salisbury, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-10-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Cokers</u>		23d. LOCATION (City, town or county) (State) <u>Greensboro, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>John E. Boulais Jr. Greensboro Md</u>		25a. REC'D BY REGISTRAR <u> </u>	
25b. REGISTRAR'S SIGNATURE <u> </u>		DATE <u>JAN 8 '62</u>	



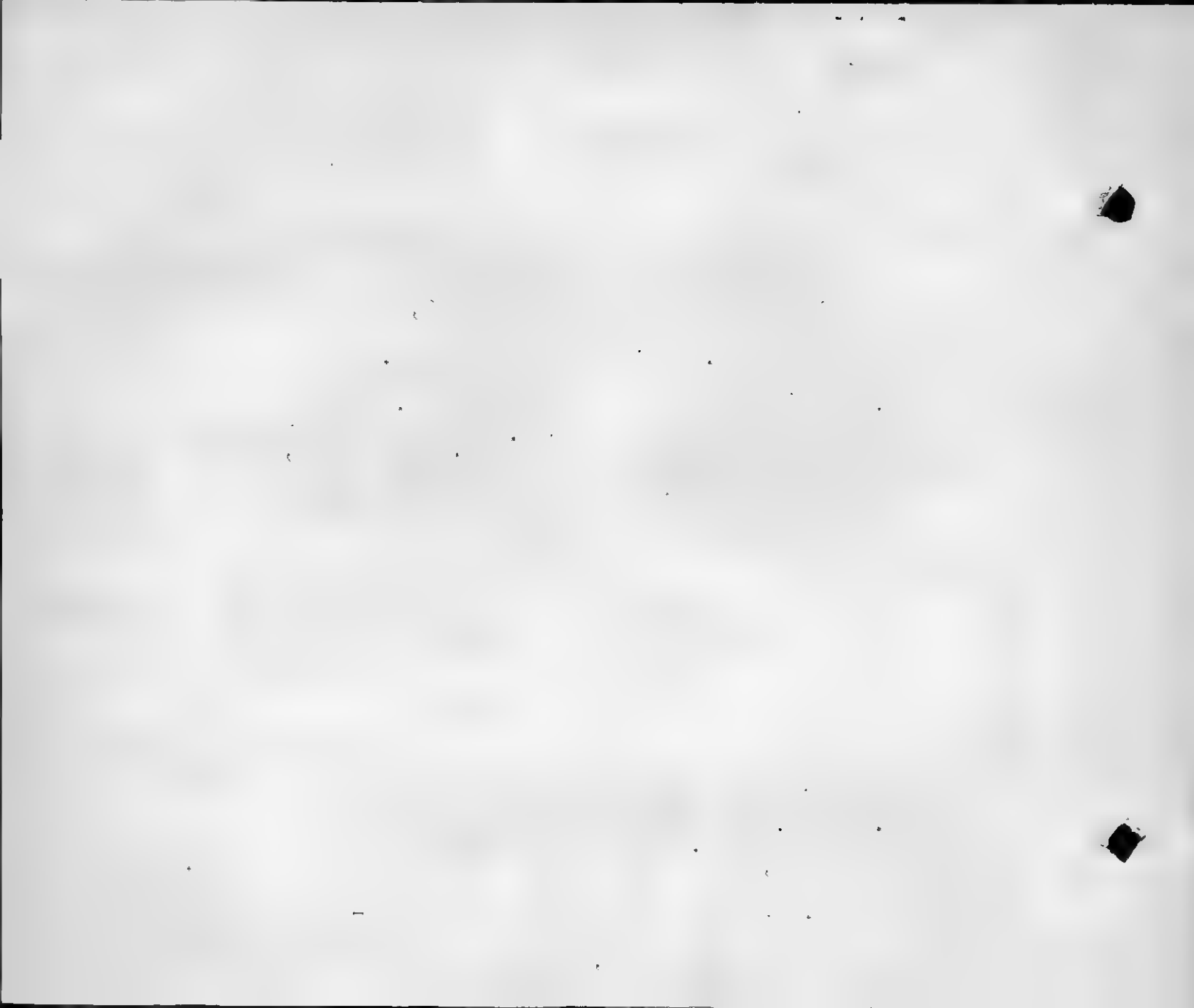
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. ATSM
5M 9/60

1
01346 MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 01328

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u>		2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Pen Gen Hospital</u>		d. STREET ADDRESS <u>904 West Main St</u>	
3. NAME OF DECEASED (Type or print) <u>ERVIN LEE SMITH</u>		4. DATE OF DEATH <u>JANUARY 13th 19 62</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 23, 1911</u>
9. AGE (In years last birthday) <u>50</u> yrs.		10. IF UNDER 1 YEAR Months <u>9</u> Days <u>20</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Refrigeration & Elect. Repairman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sussex Co. Delaware</u>	
11. BIRTHPLACE (State or foreign country) <u>U S A</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Lorenzo W. Smith</u>		14. MOTHER'S MAIDEN NAME <u>Mollie E. Records</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>17. INFORMANT Mrs. Ethel Byrd Smith (Wife)</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>428</u> DUE TO <u>Coronary Occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a). 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u> 407 Camden Ave. Salisbury, Maryland		DATE SIGNED <u>Jan. 16 / 1962</u>	
EXAMINER'S NAME (Type) <u>Salisbury, Maryland</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Jan. 17 / 1962</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park-Salisbury, Maryland</u>	22d. LOCATION (City, town, or country) (State)
23. FUNERAL DIRECTOR <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY, MARYLAND</u>		24a. REC'D BY REGISTRAR DATE <u>JAN 19 '62</u>	
24b. REGISTRAR'S SIGNATURE <u>Wesley S. Thomas</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

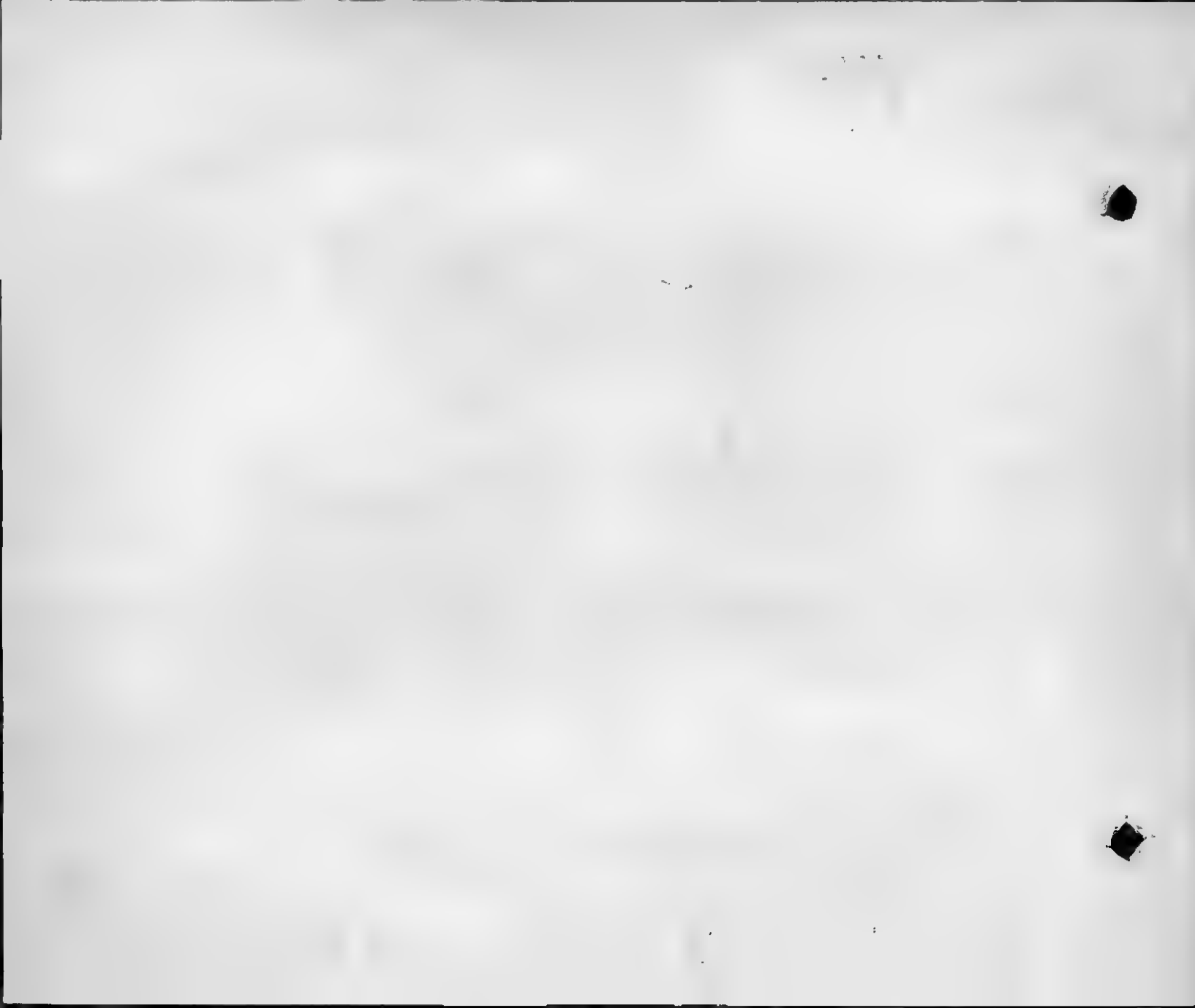
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01347

11329

1. PLACE OF DEATH a. COUNTY <u>WICOMICO</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WICOMICO</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u>		c. LENGTH OF STAY IN 1b <u>2 1/2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL HOSPITAL</u>		e. STREET ADDRESS <u>MARDELA</u>	
3. NAME OF DECEASED (Type or print) <u>JOHN HENRY STANT</u>		4. DATE OF DEATH Month <u>JANUARY</u> Day <u>31</u> Year <u>1962</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug 19, 1913</u>
9. AGE (In years last birthday) <u>48</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RESTAURANT FOOD</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>JOHN H. STANT</u>		14. MOTHER'S MAIDEN NAME <u>CLARA WESSELLS</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>219-07-6970</u>	
17. INFORMANT <u>IRIS STANT-MARDELA</u>		Address <u>MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia - Rt lower lobe</u> 490X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c) _____ DUE TO (e), stating the underlying cause last. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC MYELOCYTIC LEUKEMIA</u>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <u>19</u> a.m. <u>30</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>JUNE 1960</u> to <u>JAN 31, 1962</u> , that (I) (we) last saw the deceased alive on <u>JAN 30, 1962</u> , and that death occurred <u>12:30 AM</u> , from the causes and on the date stated above.			
22a. SIGNATURE <u>Thomas C. Hill, M.D.</u>		22b. DATE SIGNED <u>1/31/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>Thomas C. Hill</u>		22d. ADDRESS <u>Pine Bluff Rd, Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE THEREOF <u>2-2-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>MARDELA</u>		23d. LOCATION (City, town or county) (State) <u>MARDELA MD.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W. S. Spurr Co - Selmar Sel</u>		25a. REC'D BY REGISTRAR <u>FEB 2 '62</u>	
25b. REGISTRAR'S SIGNATURE <u>Conrad S. Hanna</u>		25c. DATE <u>FEB 2 '62</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

01348

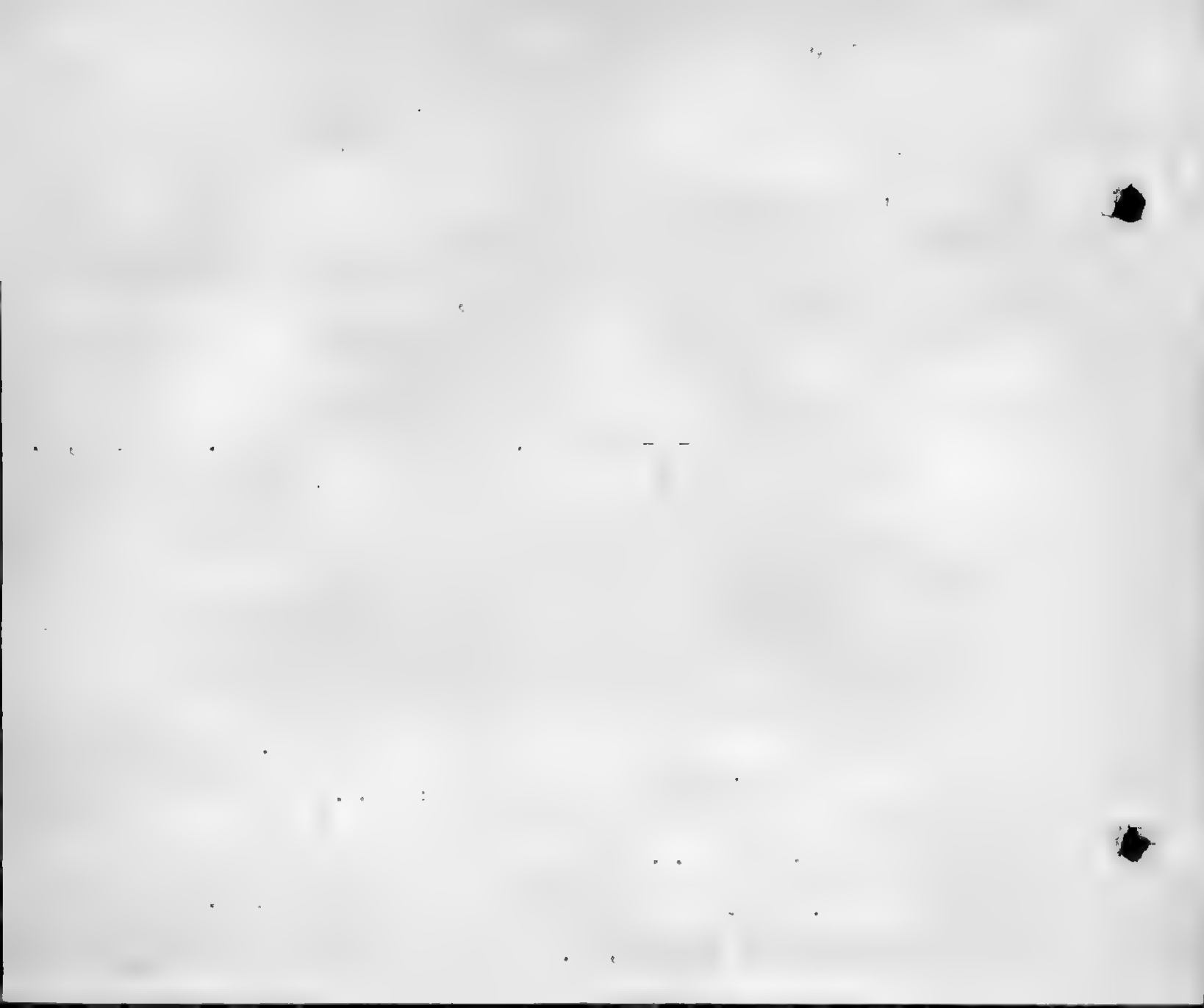
01330

1. PLACE OF DEATH a. COUNTY Wicomico		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Salisbury		c. LENGTH OF STAY in lb 9 Mos. 15 Days		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland		b. COUNTY Wicomico		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Deer's Head State Hospital		e. STREET ADDRESS Schumaker Rd.		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		3. NAME OF DECEASED (Type or print) First Middle Last Amelia Catherine Townsend		4. DATE OF DEATH Month Day Year January 13 19 62		5. SEX Female	
6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Apr. 5, 1880		9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (County & State, or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY U. S. A.		13. FATHER'S NAME Samuel Shockley		14. MOTHER'S MAIDEN NAME Henrietta Webster	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO		16. SOCIAL SECURITY NO. None		17. INFORMANT Hospital Records -- Salisbury, Maryland		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cor Pulmonale DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Emphysema Pulmonary DUE TO (c) Tracheobronchitis -- Chronic		INTERVAL BETWEEN ONSET AND DEATH ?		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 3/29/61 to 1/13/62 , that (I) (we) last saw the deceased alive on 1/13/62 , and that death occurred at 6:15 A.M. from the causes and on the date stated above.		22a. SIGNATURE V. Juerman		22b. DATE SIGNED 1/13/62		22c. PHYSICIAN'S NAME (Type) V. Juerman, M.D.		22d. ADDRESS Deer's Head State Hospital - Salisbury		22e. MED. DIR. <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 1-16-1962		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City, town or county) (State) Salisbury, Md.		25a. REC'D BY REGISTRAR Hill & Johnson Funeral Home, Salisbury, Md.		25b. REGISTRAR'S SIGNATURE Arthur L. Kraus	

TO HOSPITAL: The law requires that the death certificate be examined within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

01350

01352

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b <u>20 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Deer's Head State Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Talbot</u> ✓ c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u> d. STREET ADDRESS <u>44 Graham Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Nora Nichols Turpin</u> 5. SEX <u>Female</u> 6. COLOR OR RACE <u>Colored</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>3-31-1888</u> 9. AGE (In years last birthday) <u>73</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>LABORER</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>FACTORY</u> 11. BIRTHPLACE (County & State, for foreign country) <u>MARYLAND</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Turpin</u> 14. MOTHER'S MAIDEN NAME <u>MARY S. WILSON</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give year or dates of service) 16. SOCIAL SECURITY NO. <u>220-16-7685</u> 17. INFORMANT <u>Philip Turpin - Easton, Md.</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ca. of the left lower jaw, with metastases.</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>1961</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>1 year?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Bronchopneumonia</u>			
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from Jan. 2, 1962, to Jan. 22, 1962, that (I) (we) last saw the deceased alive on Jan. 22, 1962, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
22a. SIGNATURE <u>V. Juerman</u> M.D.		22b. DATE SIGNED <u>1/23/62</u>	
22c. PHYSICIAN'S NAME (Type) <u>V. Juerman, M. D.</u>		22d. ADDRESS <u>Deer's Head Hospital; Salisbury, Md.</u>	
23a. BURIAL, CREMATION, OR REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>Jan. 27 1962</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Richards Cem.</u>	23d. LOCATION (City, town or county) (State) <u>Easton Md.</u>
24. FUNERAL DIRECTOR'S SIGNATURE <u>James S. Doshier</u>		25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
DATE <u>JAN 30 '62</u>			

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2-1-1944

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01351

CERTIFICATE OF DEATH

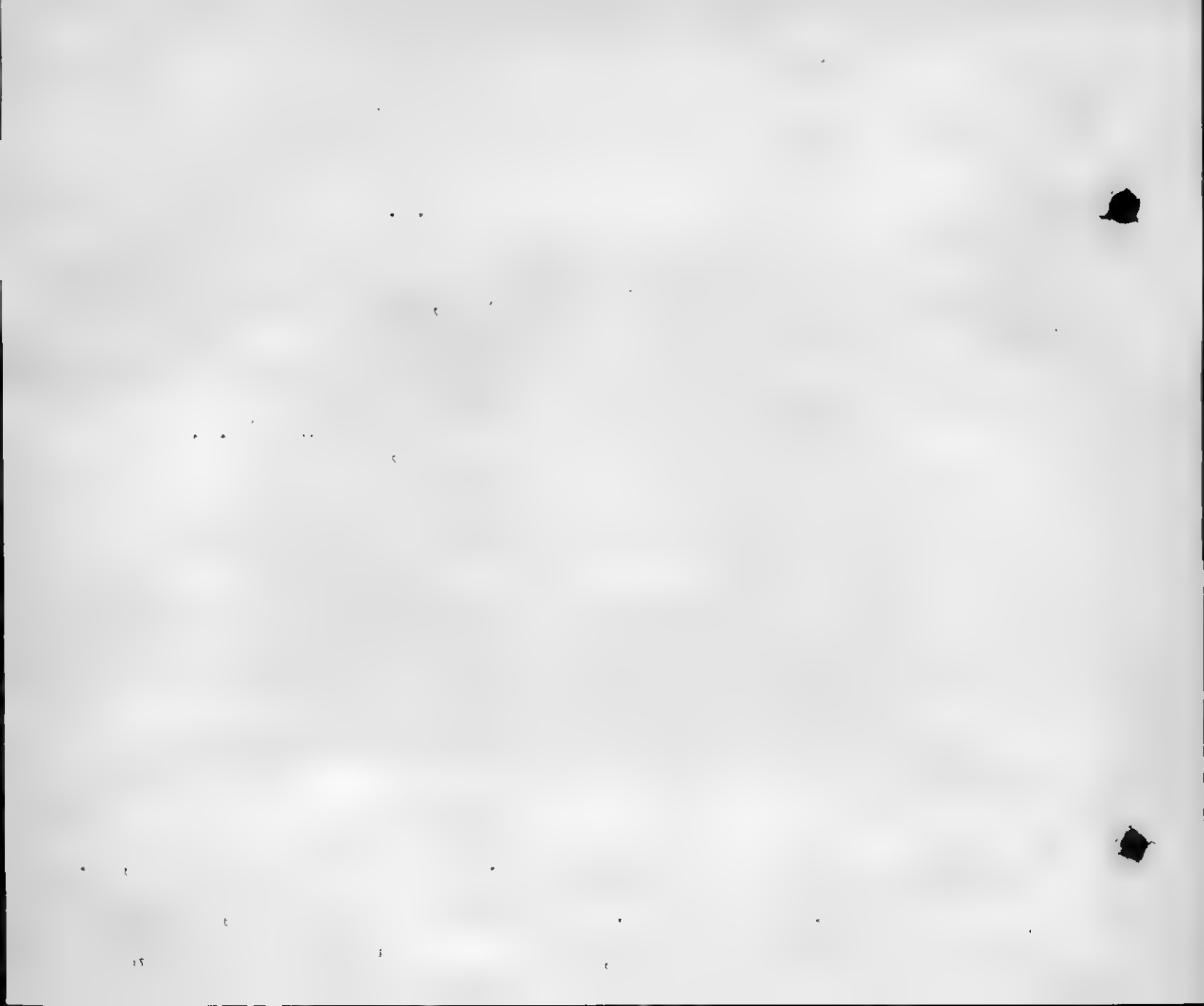
01333

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Eden</u>			
c. LENGTH OF STAY IN 1b				d. STREET ADDRESS <u>R.D.# 2</u>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Peninsula General</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Charn</u> Middle <u>ALICE</u> Last <u>Wellwood</u>				4. DATE OF DEATH Month <u>January</u> Day <u>13</u> Year <u>1962</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. AGE (In years last birthday) <u>74</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House Work</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Canada</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>Robert Wellwood</u>				14. MOTHER'S MAIDEN NAME <u>Jeanette Ames</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>Mrs Jean Preston (Sister)</u>			
17. INFORMANT <u>Eden, Maryland</u>				18. INTERVAL BETWEEN ONSET AND DEATH			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Presumed</u> DUE TO (b) <u>Metastases from Cancer of Jaw</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>12/29/61</u> to <u>1/13/62</u> , that (I) (we) last saw the deceased alive on <u>1/13/62</u> , and that death occurred at <u>5:15 PM</u> , from the causes and on the date stated above.							
22a. SIGNATURE <u>Carrie Hearn</u>				22b. DATE SIGNED <u>1-13-62</u>		22c. PHYSICIAN'S NAME (Type) <u>CHARLIE HEARN</u>	
22d. ADDRESS <u>N. Division St Salisbury, Md.</u>				22e. REC'D BY REGISTRAR			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial Jan. 18 / 62</u>				23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY <u>Wico. Memorial Park</u>	
23d. LOCATION (City, town or county) (State) <u>Salisbury, Maryland</u>				24. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY SALISBURY, MARYLAND</u>			
25a. REC'D BY REGISTRAR <u>JAN 17 '62</u>				25b. REGISTRAR'S SIGNATURE <u>Arthur L. Hearn</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, and be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Part 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

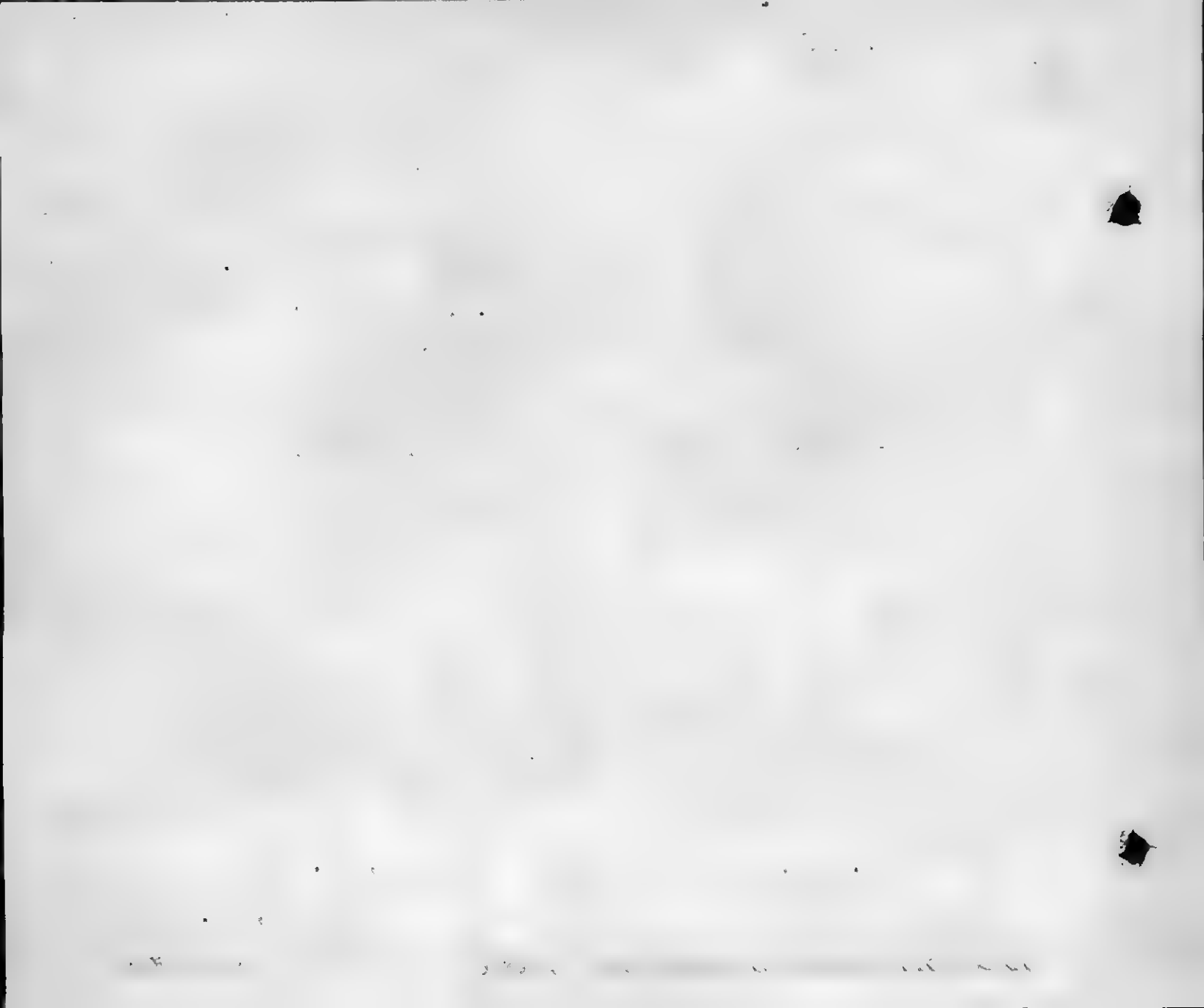
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01352

CERTIFICATE OF DEATH

01354

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> c. LENGTH OF STAY IN 1b <u>7 years</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>108 Chestnut Street</u>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Delmar</u> d. STREET ADDRESS <u>108 Chestnut Street</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROYAL</u> Middle <u>GILLETTE</u> Last <u>WESSLELLS</u>		4. DATE OF DEATH Month <u>Jan.</u> Day <u>10th</u> Year <u>19 62</u>	
5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Feb. 9, 1880</u> 9. AGE (In years last birthday) <u>81</u> yrs. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u> IF UNDER 24 HRS.: Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Farmer</u> 10b. KIND OF BUSINESS OR INDUSTRY <u>Farm Owner</u>		11. BIRTHPLACE (County & State or foreign country) <u>Virginia</u> 12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Isaac Wessells</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u>		17. INFORMANT <u>Jewel Baker, Delmar, Maryland</u> Address <u> </u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Multiple myeloma</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <u>Virus enteritis, acute</u>		INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u> </u> a.m. <u> </u> p.m. <u> </u> 19 <u>62</u>		20d. INJURY OCCURRED <u> </u> While <input type="checkbox"/> Not While <input type="checkbox"/> <u> </u> at work <input type="checkbox"/> at work <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Sept 1st 1961</u> to <u>Jan 10th 1962</u> that (I) (we) last saw the deceased alive on <u>Jan 10th 1962</u> and that death occurred at <u>5:45 P.M.</u> from the causes and on the date stated above.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
22a. SIGNATURE <u>Dr. L.V. Sohler</u> 22c. PHYSICIAN'S NAME (Type) <u>Dr. L.V. Sohler</u>		22b. DATE SIGNED <u>Jan 11th 62</u> 22d. ADDRESS <u>Delmar, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>1-13-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Parksley Baptist</u>		23d. LOCATION (City, town or county) <u>Parksley, Va.</u> (State) <u> </u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>W.S. Marvel Co - Delmar, Md.</u>		25a. REC'D BY REGISTRAR <u> </u> 25b. REGISTRAR'S SIGNATURE <u>Arthur L. Harris</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

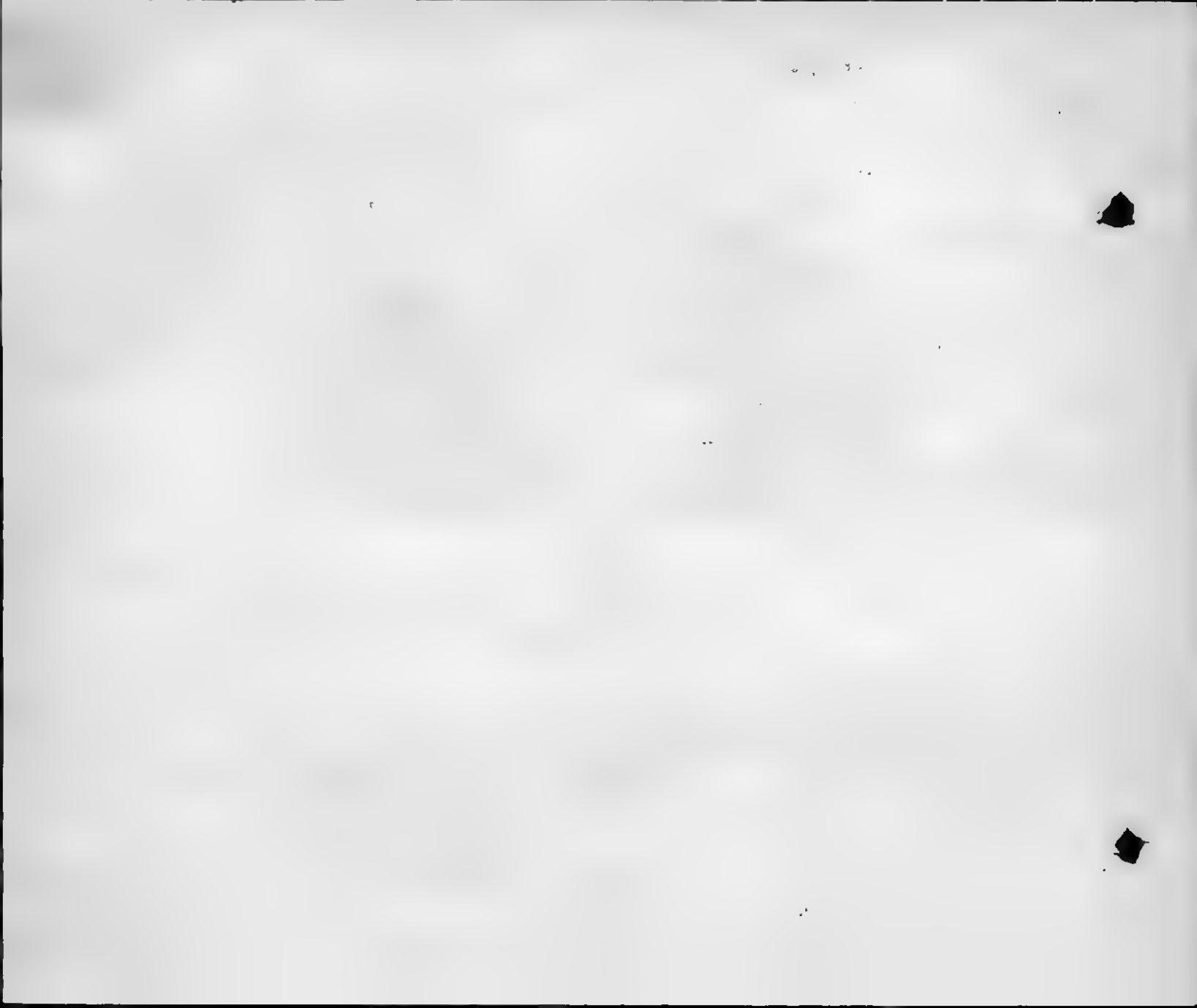
CERTIFICATE OF DEATH

01353

01353

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>4 days</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>PENINSULA GENERAL Hospital</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> d. STREET ADDRESS <u>Route #1 Box 353</u>	
3. NAME OF DECEASED (Type or print) <u>ANNA LOU WEST</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 4. DATE OF DEATH <u>JANUARY 30</u> 19 <u>62</u> Month Day Year	
5. SEX <u>FEMALE</u> 6. COLOR OR RACE <u>NEGRO</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <u>7-8-1937</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 24 yrs.		9. AGE (In years last birthday) <u>24</u> 10. KIND OF BUSINESS OR INDUSTRY <u>NONE</u> Months Days Hours Min.	
11. BIRTHPLACE (County & State, or foreign country) <u>ALABAMA</u> 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>JAMES WEST</u> 14. MOTHER'S MAIDEN NAME <u>WINIFRED ROWE</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NONE</u> (If yes, give war and dates of service)		16. SOCIAL SECURITY NO <u>NONE</u> 17. INFORMANT <u>JAMES WEST, Fruitland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <u>456 X</u> <u>Disseminated Lupus Erythematosus</u> IMMEDIATE CAUSE (a) DUE TO Conditions, if any, which gave rise to immediate cause (b) DUE TO (a), stating the underlying cause last. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>INTERVAL BETWEEN ONSET AND DEATH 1 yr</u> 19. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20c. TIME OF INJURY Month, Day, Year <u>19</u> 20d. INJURY OCCURRED <u>While at work</u> <input type="checkbox"/> <u>Not While at work</u> <input type="checkbox"/> Hour a.m. p.m.			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Salisbury, Md.</u> 20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>12:30</u> 19 <u>to</u> <u>1962</u> that (I) (we) last saw the deceased alive on <u>1962</u> and that death occurred at <u>12:30</u> from the causes and on the date stated above.			
22a. SIGNATURE <u>David Gilmore, M.D.</u>		22b. DATE SIGNED ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <u>David Gilmore, M.D.</u>		22d. ADDRESS <u>Salisbury, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>2-4-62</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Ant. Calvary Cem</u>		23d. LOCATION (City, town or county) (State) <u>Fruitland, Md.</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>Thornton B. Jolley</u>		25a. REC'D BY REGISTRAR <u>Salisbury, Md.</u>	
25b. REGISTRAR'S SIGNATURE <u>February 6 '62</u>		C. W. S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

01354

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01336

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FOR STATE
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 609 Smith St.		d. STREET ADDRESS 609 Smith St.	
3. NAME OF DECEASED (Type or print) George Clinton White		4. DATE OF DEATH Month 1-14 Day 62 Year 1962	
5. SEX M	6. COLOR OF RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH March 3, 1939
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Employee-Shirt Factory		11. BIRTHPLACE (State or foreign country) Salisbury, Maryland	
13. FATHER'S NAME Benjamin Franklin White		12. CITIZEN OF WHAT COUNTRY? U S A	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) YES		16. SOCIAL SECURITY NO. R.D.#5 High Banks - Salisbury, Maryland	
17. INFORMANT Mr. Richard L. Moore (Brother-In-Law)		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bullet wound of chest DUE TO (b) 976X Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Acute depression		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Shot self in chest with 22 calibre rifle.	
20c. TIME OF INJURY Month, Day, Year Hour 1-14-62 a.m. 1-14-62 p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Own home.	20f. (City or town) (County) (State) Salisbury Wicomico Md.
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE Earl L. Royer, M.D.		DATE SIGNED 1-17-62	
EXAMINER'S NAME (Type) Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. LOCATION (City, town, or country) (State) Siloam, Maryland	
23. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY MARYLAND		24a. REC'D BY REGISTRAR JAN 19 '62	
24b. REGISTRAR'S SIGNATURE C. L. F. F. F.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please extend the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician. Page 2 may be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, as 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
01355 CERTIFICATE OF DEATH 01337										
1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b since 12/29/61 d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pine Bluff State Hospital					2. USUAL RESIDENCE (Where deceased lived, If institution; Residence before admission) a. STATE Maryland b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury d. STREET ADDRESS 309 Penn Street					
3. NAME OF DECEASED (Type or print) BETTIE LOUISE WILLEY					4. DATE OF DEATH January 13 1962					
5. SEX F		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH October 27, 1884		9. AGE (In years last birthday) 77 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY -----		11. BIRTHPLACE (County & State, or foreign country) Dorchester Co., Maryland			12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Charles A. Johnson					14. MOTHER'S MAIDEN NAME Louise Drucilla Tyler					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No					16. SOCIAL SECURITY NO. 219-07-7736					
17. INFORMANT Mr. Charles W. Willey (Son)					18. ADDRESS Records of Pine Bluff Hospital above.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 422.1 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO (b) unknown Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) -----								INTERVAL BETWEEN ONSET AND DEATH unknown		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Emphysema								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 e.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that (I) (this hospital) attended the deceased from 12/29/61 , 19 61 , to 1/13 , 19 62 , that (I) (we) last saw the deceased alive on 1/13 , 19 62 , and that death occurred 8:00p.m. the causes and on the date stated above.										
22a. SIGNATURE E.P. Ritchings					ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 1/14/62			
22c. PHYSICIAN'S NAME (Type) E.P. Ritchings					22d. ADDRESS Pine Bluff Hospital, Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 16, 1962		23c. NAME OF CEMETERY OR CREMATORY Charity Church Cemetery- R.D.#		23d. LOCATION (City, town or county) (State) Salisbury, Md.				
24. FUNERAL DIRECTOR'S SIGNATURE Holloway & Co					ADDRESS Sal. Md.		25a. REC'D BY REGISTRAR JAN 17 '62		25b. REGISTRAR'S SIGNATURE Arthur S. Haines	

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February 4 1902